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THE DUTY LINE IN MEDICAL JOURNALISM.

BY JOSEPH R. CLAUSEN, A. M., M. D.

The most carefully edited journals are not, as a rule, either the most popular or the most successful.

This is a discouraging statement to make, and the sadder for being true, for true it is.

Were the reverse the rule, two powerful incentives would exist for the more careful editing of our columns—popularity and profit; but, since this is not the case, it is duty, not business enterprise, that calls for a closer editing of copy and galley proof; nor from title page to the "ad"

that disfigures the cover should anything escape this editorial scrutiny and revision.

It is hard, at times, to do one's duty, even when the plaudits of the populace, to say naught of their shekels, will in the end reward our efforts, but for an editor to conscientiously do his duty, recognizing at the time that in the doing of it he is lessening the popularity of his paper and the size of his income, is harder still. Yet it is the unflinching performance of this duty that we urge, insisting on it not alone for duty's sake, but because concerted action in this direction would soon restore medical journalism to the high eminence

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from which we feel it has fallen, and the faithful performance of the duty referred to would soon receive other and more substantial reward than virtue's own. In short, the entire situation would be changed and the best edited papers would at once be the most successful and popular.

It is high time that the duty line in medical journalism was drawn and universally recognized when, as a unit, the medical press shall say to the abuses that threaten its usefulness: "Thus far shalt thou go, and no farther." A line, too, that shall shut out the petty weaknesses that now impair its dignity and lessen its influence.

And what are these abuses, these weaknesses?

First, sensationalism—that bane of the newspaper press of to-day. Disguised, of course, in physician's garb, but none the less insidious in character, and all the more harmful in its influence.

Too great readiness to give space to the discussion of questionable theories, to the exclusion of sound, instructive argument in support of those that have been proven tenable.

A tendency to overshoot the intelligence of our readers, forgetting that we are writing to the many, not the few, and that every general practitioner is not a specialist.

A disposition to, at least, passively encourage professional "fads" simply because they are popular, instead of vigorously opposing them and mercilessly exposing them as fads.

A forgetfulness of the fact that we are, or are supposed to be, leaders of medical thought and not caterers to the perverted tastes of professional or literary epicures.

The ridiculous practice of expressing plain truths in such stilted, awe-inspiring language that the truths themselves are wholly obscured in the verbiage of words that clothe them.

A disposition to make our editorial columns subservient to the advertising pages, forgetting that even the negative endorsement of a medical journal has an influence that can scarcely be calculated and may be given a publicity by the advertiser that we ourselves would be most reluctant to have it given.

And last, but by no means least, the too frequent surrender to that potent factor—a yearly contract—and the acceptance of advertising that should have no place in the columns of a well-edited medical journal that respects the principles it professes to uphold.

We mean, in short, that the advertising columns should be as carefully edited as any in the paper, and that no preparation or article should be advertised that we cannot fully, intelligently and conscientiously endorse.

It is no new code of newspaper morals that we ask shall be adopted, but recognizing our high mission as the medical press of this country, that we return to first principles, those that combine honesty with common sense.

CANCER OF THE LARYNX.*

BY DR. THOMAS H. MANLEY, NEW YORK.

Dr. Manley began by submitting a diagram of the larynx, in sagittal sections, showing its relations to adjoining parts. He then reported a case of ulcerating larynx in a young woman. No two pathologists agreed on diagnosis of it; but finally assuming that it was malignant, her whole larynx

had been swept away by an operation, including three rings of the trachea and the opening into the esophagus. The unfortunate pa-

* Abstract of brief notes on Laryngeal cancer read before Celtic Medical Society, April 18, 1896.

tient survived but a few hours after operation. Dr. Manley then denounced the operation of complete laryngectomy, and said that it was a procedure so terrible and destructive in its effects on life, and mutilating in its results that it should be mentioned only to be condemned. The surgeon who advised or performed this operation undertook a very grave responsibility, and was answerable for the consequences to his patient.

He then quoted from McBride, who desired the value of microscopical examination here, of a section from the larynx, unless it penetrated deeply; as it is essential that the epithelial elements penetrated into the connective tissue layer.

Fauval noted that cancer of the larynx was very rare as a secondary affection. Morrell McKenzie and Lennox Browne each saw but one case.

Fauval, however, describes four cases of cancer commencing in the esophagus and extending into the larynx. This author, in recording 37 cases, found none in persons under 39 years; 34 were males and only 3 females. In Moure's statistics, including 179 cases, but 26 were females.

In the way of treatment tracheotomy is highly praised, as giving immediate relief and greatly prolonging life.

Semons says that from extended investigations and study, besides a case which came into his own hands, in which, after repeated examinations by the microscope, it was pronounced malignant, she made a good recovery, he believes that there are pathological conditions quite indistinguishable from cancer, microscopically, which are not malignant.

Lennox Browne says that the operation of tracheotomy in a large number is followed by a very considerable prolongation of life. In Fauval's four cases so treated, the average duration of life after tracheotomy was four years.

Cohen, speaking of laryngectomy, says: We can conceive of one liv-

ing without his larynx, and we know that there are individuals living as mutes to-day, feeding by the stomach tube, who prefer this to not living at all; nevertheless, the operation of complete removal of the larynx is hardly to be considered as justifiable in malignant growths.

The statistics in the operation for laryngectomy are not reliable, and very incomplete. Reports of the mortal cases are suppressed, and surgical operations are often set down as "successes."

For instance, in Fauval's group of 91 cases treated by laryngectomy, 30 died within 16 days; but he is silent on the other 60, as to what relief they enjoyed or how long they survived operation.

Watson Cheyne, in the Lettsonian Lectures (Lancet of issue for March 7, 1896), in a superb contribution to the surgery of malignant disease involving the pharynx and larynx, says under this topic: "It is remarkable how much we can take away in the tonsillar region without causing any great contraction or inconvenience; on the other hand, when pharynx and larynx are both removed, life is hardly worth living, except in rare instances. Certainly it is not in the case of a poor patient, who would have to spend the remainder of his days in the workhouse."

Dr. Manley concluded by calling attention to the simplicity of tracheotomy in these cases, by using cocaine hypodermically. Palliative treatment was the only safe and rational. The trachea and oesophagus were swung from the larynx, in the neck; they had themselves neither suspensory ligaments nor muscles, and hence when the larynx was amputated the gullet and trachea were drawn deeply into the chest; respiration became difficult and artificial alimentation was often exceedingly painful or quite impossible. It was well not to overlook the fact, that although the larynx is apparently superficially located, it lay in the midst of vital structures, and its dislodgment was only possible by an extensive division of vessels and a large loss of blood.

EXTRA UTERINE PREGNANCY.

BY V. BERRY, M.D., SPRINGDALE, ARK.

My attention was recently very forcibly called to the subject indicated by the heading of this article. It was the second time in my professional career, and I think the lessons learned in each case will be lasting, and to the benefit of both myself and patients. Did not see the second case reported, till death had occurred. The first case was under my immediate observation for 64 days, and though I may be accused of rank ignorance, confess to not having made a correct diagnosis till the abdomen was opened. I diagnosed the second case before seeing the victim, as will be related later on.

Case I. (This case occurred in my practice at Wagoner, I. Ty.). On the 26th day of January, 1893, Mrs. C. was sent for by a relative, whom I was attending in miscarriage. She (Mrs. C.) happened to be visiting five miles distant in the country, and as a consequence had to drive to town in one of our severest western storms, and was thoroughly chilled on arrival. (These details are given on account of their subsequent bearing on diagnosis). She assumed the duties of nurse on entering the house, and the reader knows how arduous the task of attending the wants of a woman in premature birth. A very severe acute pharyngeal catarrh was one of the results of her exposure. On the 27th she complained of a black, tarry discharge from the vagina, but remarked that she thought it due to taking cold, as she had had a slight bloody discharge for several days, and as she had not menstruated regularly for some time thought she was simply suffering from scanty menstruation and cold.

I will here state that this woman was 32 years of age, married five years, mother of two children, the youngest of which was one year, and

the oldest three years old. She had never had a miscarriage nor any of the diseases peculiar to her sex, except what was supposed to be a cancerous node on the right breast, which was removed during girlhood, and had never shown symptoms of return. Health good previous to and after marriage. She understood the laws of health as well as any one I have ever met in the laity, and through the application of that knowledge had succeeded in giving birth to two strong and vigorous children without affecting her own health in any perceptible manner. It is well to state that she was far above the average intellectually, and of the highest moral culture; hence all she said in regard to her ailments could be relied on as an intelligent statement of facts, in so far as it is possible for any patient to observe their own symptoms; and knowing her acuteness of observation as I did, I perhaps placed too much confidence in her own diagnosis, and not enough reliance on my own judgment. If I should censure myself in the treatment of this case it would be especially on that point. As I grow older in my professional work I become more and more impressed with the idea that we should depend on our own judgment to the absolute exclusion of the patient's suggestions. Not that the patients' story is not an essential factor in an intelligent history of a given case, but after the story is heard it should be sifted and analyzed and none of it adopted as a basis of counsel unless every detail will stand absolute proof, or verification by the physician's personal observation. But I digress. On the 29th Mrs. C. returned to the country feeling somewhat improved, after using the simpler remedies for catarrhal conditions. After a stay of four or

five days she returned to town still suffering from catarrhal symptoms, a dull pain—at times lancinating—in the left pelvic cavity, and a slight tarry vaginal discharge at irregular intervals. February 5 made a bimanual examination through both the rectum and vagina. Made out a small but indistinct mass in the left pelvis. Introduced speculum, and after some hesitation passed a sound to the fundus uteri. Uterus was tilted slightly to the right and was of about normal depth. Vaginal fornices were tender and pulsating, and a slight leucorrheal discharge present. The uterus was tender and the endometrium congested and inclined to bleed on slight pressure. Ovarian regions were extremely sensitive. After weighing the different symptoms in my mind, I gave the following problematical diagnosis: Cystic ovary (may be ovaries), endometritis caused by "catching cold" during menstruation at some remote period and aggravated by recent exposure and pyosalpinx (?). I put a question mark after pyosalpinx for the reason that I was almost guessing at it. The symptoms were not sufficient, yet some of them seemed to point in that direction. A satisfactory examination could not be made without full anesthesia, as pain was too great. After the above diagnosis, which as before said was very obscure and not at all satisfactory to myself, put my patient on "rest in bed," copious hot vaginal douches medicated with glycerine and astringents, and inserted tampons to the fornix vagina at night, saturated with oil of eucalyptus, terebene and menthol. Also gave the usual "female tonics"—so-called.

After using this treatment in a routine way for several days, a very obstinate constipation set in. The accumulated feces caused severe pain through pressure on the surrounding pelvic viscera. Only very larger doses of sulphate of magnesia, followed with large doses of cascara would suffice to keep the bowels open. These drugs had to be given continuously, as their cessation for a single day was immediately followed

by a tying up of the bowels. As my patient continued to grow worse, I concluded to inject the mixture of terebene and oil of eucalyptus into the uterine cavity—with little hope of result. I had read somewhere of the wonderful success some fellow had had in endometritis with this treatment, but I wish to say I do not believe all I read now. I carefully introduced a few drops of the preparation by means of a slender pointed uterine syringe. This was at 4 P. M., and I immediately left for my home, just across the street. At 6 P. M. was called in haste, as she was suffering agonizing pain. The most plausible theory as to the cause of this pain is that some of the fluid was injected through the tube, yet I can hardly accept that explanation, as only four or five drops were injected, and the os uteri was very patulous and entered with perfect ease. Extreme suffering continued for several hours, with irregular colicky pains, and there was present a constant desire to stool, but an inability to do so without the aid of an enema. She then passed a few small, round and very hard boluses. Patient was now rapidly losing both flesh and strength. In four or five days she readily consented to another uterine injection, as she and I thought it possible the colic was of intestinal origin, and simply coincident with the injection. Flatus was a constant symptom. To be brief, will say the results were precisely as before, except that my patient was in a feebler condition than after the first ordeal. I now put her on quinine (don't know why), and a general tonic and reconstructive treatment, and waited developments. She steadily declined, and judge of my surprise when on entering the room a few days later she almost insisted that I should use another intra-uterine injection. After considerable hesitation, I consented, and the result was all but fatal. I now advised the family that the only hope lay in an operation, and asked for counsel. At the patient's request I awaited the arrival of Dr. Isabelle Cobb, who was then completing her medical education at the

"Woman's Medical College," of Philadelphia. She arrived in the early part of March, and I found her to be a competent and intelligent recent graduate, with an amount of medical knowledge above the average student just from college. She was conversant with the teachings of Joseph Price, having been an attendant of his clinics. We examined the patient together, and consulted over the results, and to sum the matter up agreed on the main points and differed very little in treatment. At Dr. Cobb's suggestion we now put our patient on predigested foods, such as peptonized milk, junket, etc. She would now get better and worse by turns up to the 29th of March, when symptoms of peritonitis set in. Matters now assumed a grave aspect, symptoms pointing as we thought to rupture of a pelvic abscess. Temperature now ranged from 99 degrees to 101 degrees F., and had before been about normal at all times. The family was still backward about an operation. She rallied a little on the 30th, but we still gave the opinion that an operation was the only hope. On the 31st we prepared for opening the abdomen, and in the meantime our patient was gradually bleeding to death. Put her on the table at 12.30 P. M., with Dr. J. O. Callahan, of Muskogee, I. Ty., in charge of the anesthetic—ether—and Dr. Cobb as operative assistant. The patient being of slender build the abdomen was easily and quickly opened. The first thing that met our gaze was a large mass of clotted blood. On inserting the hand felt a boggy mass, and an elongated tumor in the left pelvic cavity. I now asked Dr. Cobb to insert her hand, before proceeding further, and to our surprise she drew forth a well developed foetus of about three months gestation. We also removed a partially detached placenta, which had had a wide attachment to the broad ligament and surrounding viscera. The bleeding was extensive, and it was out of the question to attempt to ligate all bleeding points, so we douched with hot water and packed with gauze. We saw a fatal termination was inevi-

table and so notified the family. She only lived a short while after recovering consciousness. Allow me to say to my reader that I hope he will never be placed in the position I then found myself. I had to witness life's slow but sure departure from one of the noblest woman I ever knew and one of the dearest friends my family ever possessed. She was a woman of grand character, and one whose loss to any community would be far greater than the loss of many whose names are heralded the lengths of our telegraph lines. It was the most heart-rending experience of my whole professional life, up to this time; and made me feel like throwing down instruments forever, though morally my conscience was at rest. I can never believe this woman could have been saved at that time, and it is yet a question undetermined in my mind as to whether she could have been saved on the day of tubal rupture or not, as each case is a law unto itself. The anesthetic was skillfully administered by Dr. Callahan, and Dr. Cobb rendered all the service that could be desired. On account of the early departure of Dr. Callahan, Dr. Cobb and myself held a partial postmortem. We simply removed the remaining portions of the placenta and examined the other viscera in situ. Ovaries slightly enlarged; left tube ruptured; placenta showed extensive preoperative rupture which, of course, gave great preoperative hemorrhage; which, combined with the bleeding tube, was the ultimate cause of death. If this case was lost through any fault of the attendants, it was through lack of early diagnosis; and as that was through lack of experience it can hardly be a fault; as the rarity of this accident in rural practice is well known. I have never met but two physicians who have seen a case in country practice. One can not gain experience in something he never sees, and he may read the literature on this subject ever so extensively and not have opportunity for practical demonstration, and I assure you the symptoms will simulate some of the more common pelvic diseases so closely that almost every

general practitioner will overlook an early diagnosis. Not so if he once sees and closely observes a single typical case. Of course, it is possible I could be misled a second time, as it is only human to err; but the sad termination of this case will ever put me on guard. Let me mention the fact that the literature on this subject was very meagre, up to that time, most of the standard authors dismissing the subject with as few words as possible, and seeming to be in great haste to drop all reference to what we now consider one of the most important subjects in modern surgery. Thanks to Lawson Tait, Joseph Price, and a few others, the immense mass of literature on the subject that has been spread broadcast in the past few years, is becoming systematized, and principles established on a sound surgical basis, and an untold number of lives are being saved as a consequence of their efforts.

Case II. Mrs. F., aged 37, mother of five children, the youngest of which was four years old, was taken with sudden and excruciating pelvic pain, accompanied by what seemed to be true labor pains, on the 10th day of February, 1896. On the evening of that day my friend, Dr. Christian, was called in, as the symptoms had become alarming. Of course, he could easily detect symptoms of peritonitis, but could not define a satisfactory cause, and as for myself I can not censure him for lack of diagnosis when I remember how badly I was at sea in my own case, and considered that this was his first and only case of the kind. He received a very obscure history from the patient, as she could not tell with any degree of accuracy as to whether she was or was not pregnant. She said if pregnancy existed it was of only one month's duration, and her evidence seemed to confirm this statement. She said her husband left home several weeks previous, leaving her in good health. One month previous to Dr.

Christian's call, she visited him and had intercourse, which was followed in a few days by irregular paroxysms of pain and bloody discharges. The pain increased from day to day, but not sufficient to place her in bed till the 10th of February, when, as before related, the symptoms assumed a grave character. On this day she was engaged in heavy manual labor, and no doubt ruptured the tube prematurely by sudden violent exertion. On the evening of the 11th, Dr. Christian saw her for the third time—twenty-four hours after his first visit—and seeing a fatal termination imminent immediately drove in town for the assistance of myself. On the road out we discussed the case, and I immediately pronounced it a case of extra uterine pregnancy—without seeing the patient. On our arrival at the bedside, we found the patient had expired a few moments before. Next morning we secured consent to open the abdomen, and the diagnosis was verified. A gallon or more of clotted and liquid blood had poured out into the abdominal cavity, and the right tube had a perforation which would easily admit the tip of the index finger. We did not procure the foetus, much to our regret, as the wishes of the family were that manipulations be made as short as possible. The reader knows how difficult it is to secure consent to an autopsy in private practice. The foetus was evidently of short gestation or it would have been readily found. In closing, allow me to say, that I do not claim special credit for having diagnosed this case, as the landmarks were very plain when compared with my first case. Neither can I lay any blame at the door of Dr. Christian, as I think most any of us, without experience as a guide, would have overlooked the diagnosis. Another thought—most patients of this kind will refuse an operation till it is too late to save them. I am now speaking of cases in rural practice.

VASCULAR MOBILITY AND STASIS, INTERRUPTION, ARREST
AND RESTORATION OF THE SANGUINOUS WAVE, PHYS-
IOLOGICAL AND PATHOLOGICAL

BY THOMAS H. MANLEY, M. D., NEW YORK.

THERMOSTASIS IN AMPUTA-
TIONS AND BONE RESECTIONS.

M. Paul Reclus, in his late emphatic protest against immediate amputation after mangling lesions of the limbs (*Revue de Chirurg.*, 10 Jan. '96), tells us that from the siege of Troy until the Sixteenth century no progress had been made in the technique of amputations.

During all these centuries, not only was the operative mortality large, but after results were highly unsatisfactory in a large proportion of those who survived.

The blazing or charring of the tissues, in sealing the vessels of the stump, so generally gave rise to consecutive endostitis, caries or necrosis, that painful consecutive bone resections had to be performed, the same post-operative ordeal to be gone over again. In those days they roasted the tissues; in our time we have been boiling them, with hot water.

But hot water will control parenchymatous bleeding, it may be said, Very true, but how about the ultimate effects?

On this question of amputation many have been led astray, through delusive statistics.

There is almost no end of the records of "successes," i. e., the patients survived the shock of amputation; but how fared the stump of the severed member? On this point the records are strangely silent. The economy of blood in all operations on the body is without question a matter of supreme importance, but let this be practiced in a manner not prejudicial to the vitality or integrity of the structures involved.

Thermostasis induces its destructive action, on the divided living bone, in two ways:

1. By at once killing the outer lay-

ers of the exposed protoplasmic corpuscles, in all the structures divided.

2. When the temperature is not too high, by provoking irritation.

If we expose living leucocytes to the action of water, raised to a temperature varying from 100 to 130 degrees, no marked influence on their movement is produced, but when the temperature is raised to 150, motion ceases; while in water of high temperature—170 to 200—the protoplasm coagulates, swells and breaks up into granules. Precisely the same phenomena follow the application of extreme heat on any other tissue.

In the shafts of bones the greater part of the arterial supply is through the vessels which penetrate the surfaces through lacunar depressions of the periosteum; in the growing child the main springs rising in the true bone roots, the epiphyses; these sending off streams in opposite directions. The venous or residual blood is chiefly conveyed through the long, parallel Haversian systems; these canals consisting of expanded, tubular tunnels, which are lined by endothelia, resting on an exceedingly delicate substratum of lymphoid tissue. Besides, through these systems in the bone, the venous blood occupies a major part of the vascular structure of bone marrow; especially, in those about or beyond middle life.

In these structures the mischief commences after parboiling the bone. It is generally well known that, as a rule, pathologic processes in osseous tissues are slow in their work of destruction or transformation. For example, a divided muscle will unite, or go to pieces in gangrene, much more quickly than an osseous structure. And, therefore, why it is, only after the stump has closed well in,

that we are cognizant of insidious advance of osteo-myelitis in the stump.

The primary effect of hot water is to coagulate organic elements. The vessels are all thrombosed by a solid coagulation of the blood and a singeing of the open ends of the vessels.

But now, instead of a regular surface resorption of the divided end of the bone, inflammation begins, with interstitial, fatty changes succeeding. Infarcts of fatty matter block the venous channels, and in this manner, step by step, advance is made, until a vast area of the solid framework is reduced to a soft, punky, oily state.

In connection with this post-operative, fatty softening of bone, which I have only seen follow in these amputations, wherein hot water has been used as a styptic, or strong bichloride solutions as an antiseptic, there were two features worthy of special notice. One was, that in no case did the overlying soft parts participate in the degenerative changes of the skeleton, nor even present, in any degree, evidence of the underlying pathological changes in the bone.

Another was even more inexplicable to me, and cannot be well explained by any study of the changes in the bone elements.

It was this. In one case following a medio-tarsal amputation of the foot these inflammatory changes, resulting in softening in the stump, not only

extended backward through all the remaining tarsus, but jumped the articular isthmus at the angle, and extended well up both shafts of the tibia and fibula. The same phenomenon occurred in a knee case. Here I found that condyloid heads of the femur and the shaft as far up as origin of Winslow's ligament were soft, oily and broken down, as in the stump where resection was commenced.

It would scarcely do here to seek for an explanation, in the old subterfuge of dissemination through the lymphatics of blood vessels; for as far as we yet know, the bones have no lymph vessels, and although all the joints, and the knee in particular, have many recurrent arterial branches, they carry the blood away from, and not above a joint. Besides if the pathology of this progressive softening could be explained in this manner, it should equally apply to traumatic gangrene of any of the infectious diseases of bone, which as a rule is not the case.

Our only rational explanation is through the trophic nerves. The capsule and ligaments mechanically connect the ends of bones together; but at this link there is some description of a vital bond, which through a sympathetic irritative or devitalizing action may carry over this bridge and visit on the head of an innocent member the same calamitous changes as primarily involved its fellow beyond.



Editorial

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DEATHS FROM CHLOROFORM.

One rarely picks up an English medical journal which does not contain one or more accounts of death from chloroform administration for anesthetic purposes. It is remarkable what risks English surgeons will run to give chloroform in place of the safer drug, ether. To be sure chloroform has its advantages, but it is a question whether its disadvantages do not outweigh the former. The following from a recent issue of the London Medical Times contains some important points relative to the administration of chloroform.

"An inquest touching the death of Ernest Henry Sinclair Tinsley, aged 15 years, son of Mr. W. H. Tinsley, a local solicitor, who died whilst under the influence of chloroform for the purpose of teeth extraction at the surgery of Mr. Edgar Morris, surgeon-dentist. The mother of the deceased stated that she took her son to see Mr. Morris, who advised him to have 11 teeth extracted, and Dr. Bellingham was engaged to administer the chloroform. Dr. Joseph Bellingham stated that he carefully examined the heart and chest with the stethoscope, and as the result he

came to the conclusion that he was justified in administering chloroform. The anesthetic was applied on a towel. Insensibility having been produced, one tooth was extracted, when deceased showed signs of recovery, and witness again administered the chloroform. He could not say exactly how long deceased was under the direct influence of chloroform, but he should think it would be about 20 or 25 minutes. After the second application of the anesthetic the remainder of the teeth were extracted, and during the operation no serious symptoms were observable. As witness returned from putting away the towel containing the chloroform, he noticed that there was something wrong with deceased, and he pressed the chest, the action being answered by a more or less responsive respiration. Artificial respiration was at once resorted to, and continued for over 40 minutes, but deceased expired. Deceased was a little longer getting under the influence of the chloroform than was ordinarily the case under such circumstances. No more chloroform was given than was necessary to get

eous impression that Carter's thermo-inhaler is unsuitable for successful ether administrations. Dr. Snow found that by means of his inhaler one ounce of ether is usually inhaled by an adult for producing anesthesia of which fully one-half is not absorbed but exhaled again.

"Dr. Carter has, however, shown that by his method, ether anesthesia is induced and maintained for eight minutes with a loss of four drachms of ether from the bottle; for six minutes, with six drachms; 15 minutes, seven drachms; 12 minutes, seven drachms; ten minutes, six drachms; and 13 minutes, six drachms, unique uniform results, which, if considered, must prove its greater safety over that of every other method of ether administration, including that effected with Clover's ether inhaler, and its various modifications, in which, contrary to the general opinion, the quantity of va-

por administered is not under perfect control, and, on that account, obviously cannot be regulated, and no one knows the quantity of ether inhaled by the patient. Returning to chloroform administration it is stated that by the so-called "open" method five and a half ounces of chloroform were administered to an alcoholic man of 56 in one and a half hours. On this point Snow says: "I have always found that hard drinkers were rendered insensible, and even comatose, by the same amount of ether or chloroform as other persons, but they sometimes have a morbid excess of sensibility in the nerves of common sensation, and do not lie still under the surgeon's knife, except when the nervous centres are deeply narcotized and the breathing almost stertorous. On this account they sometimes inhale much more chloroform during a protracted operation than other persons."





SOME OF THE USES OF ELECTROLYSIS IN DERMATOLOGY.

Dr. C. W. Allen states in a paper read before the Lenox Medical Society that electrolysis has a varied application in the treatment of skin affections. It is not alone in hypertrichosis, or unusual growths of hair in unusual and undesirable locations, that the electrolytic needle finds its sphere of greatest usefulness; it use extends to the removal of smaller tumors, naevi and to the cure of a number of other abnormal conditions of the skin.

Referring to the question of what result can be promised an applicant for relief from a disfiguring growth of hair the author says "that many sittings will be required and a certain proportion of hair will grow again and require subsequent removal.

"To illustrate: Miss W. came to me from Connecticut in March, 1894, and in several sittings, extending over a week's time, I removed three hundred and fifty-seven long coarse hairs from the upper lip and chin, destroying at the same time a small vascular naevus upon the cheek.

"I told the lady that within some months certain of these hairs removed in which the point of the needle had not exactly touched the hair papilla would grow again and that it was to be expected in the natural course of events that a certain number of other hairs now present, but fine and devoid of pigment, would grow larger, coarser and darker. I was not therefore surprised to see the lady again in January, 1895, nor was she surprised at the necessity for her return to me.

"I now found 57 hairs requiring removal from the upper lip, 27 from the left side of the chin, 16 from the right side, and 55 from all other portions of the face, making a total of 155, or over 200 less than eight

months previously. I have not seen the patient since, but no doubt there are again present 50 or more hairs requiring attention."

Considering the question of whether electrolysis tends to simulate the growth of neighboring hairs, Dr. Allen believes that to a limited extent the irritation of the surrounding tissues caused by the current and the succeeding erythema favor increased activity in the growth of near-by hairs which are at first ignored; but it will not cause new hairs to grow on a bald head.

This author thus considers the question which has been raised as to whether it is consistent with professional dignity and strictly within the province of the physician to do this kind of work. "If the female beard is to be destroyed there is only one method now known, in my opinion, which will do it effectively, viz., electrolysis, and there is only one class of people who should practice it, viz., the physicians. I have had many applications from young women who wished to be taught how to operate, but my invariable reply has been that no one but a physician should attempt it. The electrolysis of the bathing establishment, of the advertising dermatologist, and of quacks in general, who know more about extracting money from their victims than they do about extracting hairs, has done much to cast discredit and odium upon a useful method. Any painstaking physician can readily acquire the requisite skill, and then all that is needed is patience, care and good judgment. It is inconsistent with good work to devote more than an hour at a time to a case, removing 50 or 60 hairs, as the work is trying and the operator is ready to stop before the patient wearies.

Several varieties of naevi are removed with greater facility and satisfaction by the electric needle than by other methods. Thus the small nevus araneus, deriving its name from the spider-leg-like appearance of the offshoots, is destroyed sometimes at one sitting by puncturing its central portion and passing for a few seconds a current sufficiently strong to decompose the contained blood and bleach the whole area involved. Telangiectases, which occur later in life, and nevi of limited extent, are removed with equal ease; while quite extensive superficial port wine mark or nevus vinosus may, with time and persistency on the part of both patient and physician, result in a very satisfactory condition. Here very superficial prickings of the needle, while painful, give better results than deeper insertion of the point and longer passage of the current.

Nothing succeeds better than electricity in naevus pilosus, especially those bearing a few stiff, deep rooted hairs. These, I destroy first, making use for this purpose of a greater current strength than in ordinary hirsuties.

The hairs being thus removed, sometimes very little in addition is required. If, however, the mole is large I use a flat-bladed sharp-edged needle, passing it through the base of the growth at the skin just as I do in nevus papillo-matosus, nevus lipomatodes and warty growths in general.

My method here differs from those hitherto advised. The usual instruction is to pass the needle through the growth in various directions, and when sufficient effect has been produced to allow it to shrink up and fall off in the course of a few weeks. This delay in final results led me to employ the flat-bladed needle. Pass-

ed through the entire base of a small growth or through a segment of a large one, the apex being grasped by a mouse-tooth forceps, it is slowly but firmly moved, perhaps with a sawing motion, first through one side and then through the other.

This leaves a level skin surface, usually bloodless, and in many instances is alone sufficient to effect a cure. If, however, the growth appears to penetrate much beneath the skin, or if there is left a central bleeding point or if the margins are not quite leveled off, the point of the needle can be used to puncture and thus destroy the necessary amount of tissue. The less done this way, however, the better, and the less chance of any subsequent scarring.

A case was exhibited of a lady who had upon the cheek just below the right eye a papillomatous pigmented and hairy mole one and a half centimetres in diameter. She was operated on by the flat needle, removing sections by the electrolytic cut at several sittings. The scar was still somewhat red at times, and slightly uneven, but was much less noticeable than a scar after excision with the knife would have been.

The author has also employed electrolysis in elephantiasis, lupus, keloid, acne rosacea, milium, and a variety of other conditions. He believes it to be the very best method of treating xanthelasma of the eyelids. He has been much pleased with the needle as a means of obliterating dilated sebaceous follicles and crypts. In obstinate comedones a three-angled or glovers needle, passed well into follicular canals, may often arrest the reformation of the plug. Upon the nose I have entirely closed up in this way dilated and very annoying follicular openings. Freckles are also removed by a modification of the method.

Med. Record.

Book Reviews.

FOR THE REVIEWER.

Twentieth Century Practice. An international encyclopedia of modern medical science. By leading authorities of Europe and America. Edited by Thomas L. Stedman, M. D., New York city; in twenty volumes. Volume V, "Diseases of the Skin." New York: William Wood & Company. 1896.

The contributors to this volume are well-known authorities in skin diseases; their respective parts are clearly and practically written, as well as exhaustively.

Beginning with the anatomy of the skin, the text passes at once to parasitic affections, by Dr. Bulkley, of New York. Erythematous affections are then taken up by Dr. Whitehouse, also of New York. Eczema and dermatitis follow, by Dr. J. N. Hyde, of Chicago. Squamous and ulcerative affections are treated by Dr. H. Radcliffe Crocker, of London, and the papular, by Dr. L. Brocq, of Paris. Bullous and pustular affections follow, by Dr. Whitehouse.

Dr. Van Harlingen, of Philadelphia, takes up diseases of the sebaceous and sweat glands, and Dr. D. W. Montgomery, of San Francisco, diseases of the hair and nails. Benign Neoplasms is the subject of Dr. Bowen, of Boston, and Xeroderma Pigmentosum that of Dr. Moriz. Dermato neuroses is treated by H. Leloir, of Lille, which winds up the volume.

It is impossible to give an accurate description of the value of this volume to the medical practitioner, for we know of no work on skin diseases which so favorably compares with the exhaustive treatises herein contained. While the plates are not

numerous for the size of the work, yet the description is very clear and well-drawn. Practitioners should have this volume of the series, if no other, at least those who are in any way interested in skin diseases, and we believe most every practitioner finds these affections among his most troublesome ones to treat successfully.

VITA SEXUALIS. Zeitschrift zur Erforschung des Geschlechtslebens und zur Ausbreitung des Verstaendnisses fuer die anthropologischen, kriminellen und hygieinischen Seiten des Letzteren. Herausgegeben von Ewald Paul. V. Malende, Verlagsbunchhandlung, Leipzig, Thalstrasse 5.

The first numbers of the above periodical have just come to hand. It is not very difficult to form a conception of the purpose and aim of this newcomer in the world of journalism, for the principal part of the reading matter has reference to the great economy in midwifery fees to be procured by the use of "pessaria occlusiva" and their recent modifications and improvements over the old-fashioned and oft-times rotten devices patented by the late Captain Condom, R. N.

Other highly edifying articles on the use of a new "hose supporter" in the form of a spiral spring that should be so placed as to reinforce that portion, between toe and heel, that is most liable to weakness from advancing age or retreating youth, may be found in every number.

The February and latest number of this exceptionally erudite journal contains a most learned dissertation upon the dangers of criminal abor-

tion and the most approved method of performing the same.

The "masters" most referred to by the writers of these articles are v. Krafft-Ebing and A. Tardieu, both of whom, no doubt, would feel highly flattered at the honor shown them.

Onanism, its rapid and certain cure by hydrotherapeutic measures, and occasional, "accidental" mention of a certain water-cure sanatorium wind up the reading matter, while the advertisements are on a par with the text.

CHANDLER.

DONT'S FOR CONSUMPTION. By C. W. Ingraham, M. D., Binghamton, N. Y. 1896.

This work is intended for physicians and consumptives, to instruct them in preventive treatment. There are many valuable points, which we observe, in respect to cleanliness both for the patient and his surroundings. The book is based upon the dicta of many of the Health Boards in respect to the contagious element in consumption. We have yet to see a case where clinically we could say direct contagion has produced phthisis in the human being, but agree that, theoretically, the possibility may exist, the victim from heredity or other cause, being in

what we have termed a pretubercular condition upon which the development of the bacillus within the body only depends.

Dr. Ingraham rightly advocates the rest treatment in certain cases of pulmonary consumption and his book should have a ready sale on its merits alone.

SYRUP OF HYDRIODIC ACID. By R. W. Gardner, New York. Thirteenth edition. 1896.

CHEMICALLY PURE HYPOPHOSPHITES. By R. W. Gardner, 156 William St., New York. Thirteenth Edition. 1896.

These two brochures are combined in one volume, and follow the usual order of the previous editions. Dr. Gardner is recognized as the pioneer in the preparation of that difficult combination known as syrup of hydriodic acid, i. e., iodide of hydrogen and non-irritant iodine; a most valuable alternative. As to hypophosphites it is well known that there is nothing so valuable in the treatment of the early stages of phthisis as the chemically pure syrup. Dr. Chunhill's views are brought out as in previous editions, and much valuable data added. We believe this book can be obtained free by application to Dr. Gardner.

THE SENSORY NERVOUS SYSTEM IN DIAGNOSIS. THE REFLEXES. A Contribution for College Students. By Charles H. Hughes, M. D. Reprint from *Alienist and Neurologist*, January, 1896.

MOVABLE KIDNEY. By Charles P. Noble, M. D., Philadelphia. Reprinted from *Gaillard's Medical Journal*.

TECHNIQUE OF EMPTYING THE UTERUS IN INEVITABLE ABORTION. By Charles P. Noble, M. D. Reprinted from *Codex Medicus*, December, 1895.

NEPHRITIS OF THE NEWLY BORN. By A. Jacobi, M. D., New York. Reprinted from the *New York Medical Journal* for January 18, 1896.

Current Medical Literature.

ULCERATIVE CHANCRIFORM TONSILLITIS.

A crateriform ulcer on one tonsil, with a sloughing base and somewhat indurated edges, has been observed in several cases by Mendel (*Arch. Internat. de Laryngol.*, November and December, 1895). It was accompanied by considerable dysphagia and by slight swelling of the corresponding glands. It gets well in a few days under the action of iodised applications and boric gargles. This affection is apt to be mistaken for primary syphilis, but it is to be distinguished from it by its rapid evolution and the slightness of the glandular enlargement.

—British Med. Jour.

THE BACILLUS OF CHANCROID (VENEREAL ULCER).

Colombini has been working on this subject, and publishes his results in a pamphlet. He finds that the bacillus of Ducrey and the strepto-bacillus of Unna are one and the same organism, characterized by being found in chains, by staining chiefly at the ends and not in the centre, by being decolorized by Gram's or Kuhne's method, by the difficulty of obtaining pure culture since a suitable nutritive medium could not be found, and by the rounded ends of the individual bacilli. The best staining agent was methylene blue. Inoculation into animals was uniformly negative. The bacillus is rarely found in bubonic pus.—B. M.J.

RUPTURE OF GALL BLADDER.

A rare accident occurred in Dorchester recently, by which a young man, 19 years of age, lost his life through rupture of the gall bladder. The victim was seized with violent

vomiting, when, suddenly, sharp pains in the region of the right hypochondrium occurred, increasing in severity until he died in about six hours. On autopsy it was found that the gall bladder had burst into the peritoneal cavity. There was no indication of prior distensions or jaundice, and it seemed to be due simply to the act of vomiting. The case is extremely rare, and occurred in the practice of one of my colleagues.

F. S. Parsons, M. D.

CHLOROSIS.

Meinert is struck by the frequency of anteruptosis in this disease, and regards the essential pathology of the affection as a neurosis dependent upon the descent of the stomach, and consequent irritation of the solar plexus. The frequency of the affection in girls is accounted for by the injurious effects of improper clothing during the period of rapid development. In cases of descent of the other abdominal viscera, high-grade secondary anemias, differing somewhat from chlorosis, are met with, and probably are the result of irritation of other nervous plexuses. In the case of chlorosis the nervous affection leads to disturbance of the blood-making functions in the spleen.

—Gould's Year-Book.

HYPNOTIC VALUE OF TRIONAL IN CHILDREN.

At a recent meeting of the Academy of Medicine Dr. Moncoro stated that, owing to the irregular effects and dangers of other hypnotics, he had been led to use trional. It had succeeded perfectly in the insomnia of the eruptive fevers—measles, scarlatina, variola—and in malaria. The dose employed was three to four grains before bedtime. In tubercu-

lar meningitis it had secured sleep and tranquillity, which played a large part in the cure of the patient. In pernicious malarial fever, with much cerebral excitement, eight grains, a half-hour before the paroxysm was expected, procured calm sleep. It seemed of little service in maladies of a painful nature. Children show a peculiar tolerance for trional. Given in warm sweetened milk, between the limits of 3 and 15 grains in the 24 hours, it might be continued several days in succession. In conclusion, trional seemed to be the hypnotic the most prompt to act and the best borne. It is more valuable, because it seems to have a specific action upon the nerves and psychic excitations of toxic origin and those in lesions of the brain and its envelopes.

—Tribune Med., No. 36, 1895, p. 726.

THE GUAIACOL-CARBONATE TREATMENT OF TYPHOID FEVER.

Dr. S. Frankel (Wiener Medizinische Blätter, February 27, 1896), writes editorially on the treatment of typhoid fever and phthisis by Guaiacol-Carbonate as follows:

In the year 1894, Dr. Hoelscher first called attention to the advantages accruing from the use of the neutral carbonic acid ether of guaiacol, guaiacol-carbonate, in the treatment of typhoid fever. He shows more especially that the site of decomposition, therapeutic action, and resorption of the drug is to be found almost exclusively in the small intestine. The fever is not influenced by it when antipyretics are not given; for guaiacol-carbonate has no such action; but the temperature falls with greater rapidity and certainty when guaiacol-carbonate and antipyrin are administered together than when antipyrin is taken alone. He found that there frequently occurred a small fall a few hours after the first dose of 1 to 2 grammes (15 to 30 grains). This was a direct consequence of its local action in the intestines, and was of good prognostic significance. When guaiacol-carbo-

nate was given early it was frequently unnecessary to treat the fever at all, and the disease ran a mild and rapid course. Dr. Seifert proved the non-poisonousness of the combinations of guaiacol and creosote with carbonic acid.

TREATMENT OF LEPROSY.

Although the clinical appearances of leprosy were well known to the physicians of a remote period it is only quite recently that its pathology has been established on a scientific foundation. Bacteriological researches have shown that it is due to a specific micro-organism, and that in many respects it resembles tuberculosis and lupus. Notwithstanding the new light thrown upon the pathology of the disease, however, the therapeutics are still almost as unsatisfactory as before and it is therefore of more than ordinary interest to note the successful results obtained by Dr. Goldschmidt from a new remedy. The patient, a woman presented well marked leprosy lesions over the face, the disease being of nine years duration. Having experimented with iodoform in cases of leprosy, without success, the author noted the use of euphen, as the most available substitute which was first administered internally. As this proved inefficient, however, he next tried hypodermatic injections of alcoholic and ethereal solutions, but soon discarded them on account of the pain produced, while the injection of oily solutions (euphen 5.0, olive oil, 95.0 gm.), was also unsatisfactory, because of the difficulty of introducing it into the firm resisting tissues. Finally, it was found that by rubbing the oily solution of euphen into the leprosy nodules and by application of compresses moistened with the oil, a beneficial influence could be exerted upon the diseased areas. The injections were employed three times daily for a minute at a time, while the compresses were worn at night in form of a mask; a cotton tampon soaked in the oil was also introduced into the left nostril, which was the seat of leprosy infiltration, this be-

ing renewed three times a day, and allowed to remain all night. After about five years treatment with euophen in this manner a complete cure has been effected which is evidenced by the entire disappearance of the characteristic bacilli, while the leprous lesions have also vanished, leaving the skin somewhat atrophied and discolored in some places. In view of the well defined character of the nodules on the face, it is remarkable how slight were the changes in the structure of the skin left after their disappearance. In Dr. Goldschmidt's opinion, there can be no doubt, but that the cure was obtained by the energetic and prolonged treatment with euophen, and that its iodine component in the nascent state is chiefly to be attributed to the bactericidal effect of the remedy. At any rate this report of a cure in a disease which has proved so obstinate to therapeutic measures of all kinds should stimulate physicians practicing in countries where leprosy prevails to give this method of treatment a careful and thorough trial.

GLUTOL-SCHLEICH.

(Powdered Formalin-Gelatin.)

In view of the importance of Formalin-Gelatin in the treatment of wounds, as proposed by Dr. C. L. Schleich, and the approval that it has already received in scientific circles, we deem it necessary to call your attention to the following facts:

It is the Formalin-Gelatin of Schering's manufacture only that Dr. Schleich has employed, that is prepared under his supervision, whose satisfactory action he is responsible for. This supervision is absolutely necessary in a new product, so as to insure its efficacy. Only by a continuous clinical control on the living organism by its inventor, can its usefulness be vouched for. We would remind you that it is not a question of mechanical action and chemical disinfection of wounds, but the application of an entirely new principle and method in surgery.

Only the Formalin-Gelatin made by The Chemische Fabrik auf Ac-

ten, formerly E. Schering, Berlin, which they have called "GLUTOL" for convenience sake, has the approval of and bears the name of Dr. Schleich.

HOW TO DIAGNOSTICATE SEXUAL DERANGEMENTS IN THE MALE.

Dr. Eugene Fuller, of New York, has endeavored to impress upon the profession the fact that in the majority of instances sexual derangements in the male were caused by pathological processes in or about the seminal vesicles, and, further, that they accomplished their results by interfering with the mechanism of ejaculation. He called attention also to the fact that this side of the question had been almost wholly neglected by preceding writers on sexual disorders, who had devoted themselves largely to psychological conditions in this connection, the result being that the great majority of the profession associated sexual disturbances with some radical mental defect. Sexual derangements in the male should be diagnostically arranged in four classes: 1. Those dependent on inflammation of the seminal vesicles. 2. Those dependent on neuroses. 3. Those dependent on primary mental disease or degeneration. 4. Those dependent on general malnutrition and debility. The order of this classification corresponded to the frequency with which these different forms of diseases were encountered in practice. In explanation of the first class of cases the writer stated that it was needless to go into details, since he had recently reviewed that subject very fully in a book.

Where inflammation of the seminal vesicles existed, there was generally a previous history of urethral or bladder inflammation, sexual abuse, and the like, all of which were agents tending to produce localized inflammation in the seminal vesicles. The second class of causes either inhibited or excited the sexual centre by means of reflex nervous action. The third class included the different forms of paranoia, in which the sexual sense existed in a perverted form. The

fourth class was a small one. It included individuals, generally young or middle-aged, who made complaint that they were capable of little sexual exertion and that feelings of prostration and exhaustion resulted whenever coitus was attempted.

The writer made some special remarks on the different appearances that the varying grades of inflammation of the seminal vesicles present to the sense of touch, and called attention to the fact that in cases of extensive adjacent inflammation involving both sacs an inexperienced examiner was likely to err in diagnosis, mistaking the condition for hypertrophy or inflammation of the prostate. The author held that to become perfected in the feel of the seminal vesicles the finger needed as much practice as that of the gynecologist did in feeling the ovaries and the tubes. To obtain the necessary practice, he advised the genito-urinary surgeon to make it customary to examine in this manner every male patient coming into the clinic until all normal and pathological conditions could be fully appreciated.

—N. Y. Med. Jour.

CHANCERIFORM ULCERATIVE TONSILITIS.

Besides the classical form, there is another lesion of the tonsils, which the author has observed six times, a kind of tonsillitis of cold evolution, which has been deceptive to the most distinguished syphilographers. The patient experiences on one side of the throat slight dysphagia at times other than deglutition. A few days previously he may have observed a small ulceration on one tonsil. This is circular, with a congestive zone, more or less deep, whitish, and, in fact, a tonsillar sphacelus. The edges are indurated. There are slightly enlarged maxillary glands. There is generally no fever. The ulceration remains stationary a little, then repairs in variable time, not often more than a week. In one of the author's cases it was three weeks. Treatment consists in iodine applications and boric gargles.

The diagnosis might be of tuberculosis or syphilis, and the latter might be tonsillar chancre or gumma. In tonsillar chancre there is great cervical glandular enlargement; in chancreiform tonsillitis adenopathy exists, but is at its minimum, consisting of only two or three slightly-developed glands, rolling under the finger. It lasts only about a week, chancre taking six weeks to develop. Gumma would be preceded by other signs of syphilis, but in doubtful cases the duration of the lesion and efficacy of treatment would settle the diagnosis. The ulcerations of hereditary syphilis are rarely limited to the tonsil. It much resembles a herpetic lesion of which the vesicular stage has been passed unperceived. The author cites six cases.

Moure. Acute ulcerative lacunar tonsillitis.

Joal recorded a case of tonsillar ulceration, which he was inclined to think tubercular. Dr. Thorne thought it to be syphilitic, but Prof. Fournier rejected all idea of syphilis. Probably it was only lacunar ulcerative tonsillitis.

Helme cited Garel's sign—viz., that prolonged dysphagia constitutes the characteristic of syphilis in pharyngeal affections of doubtful diagnosis. When dysphagia lasts more than three weeks it is certainly a syphilitic lesion.

Povet had seen cases resembling those described. They resembled tertiary syphilis, and were all improved under iodide.

Moure: Tonsillar chancre cannot be mistaken. In herpes, too, there is intense dysphagia, rapid evolution and disseminated lesions. It is not so with tertiary lesions, and he believed that the ulcerations described had a lacunar origin.

Martin had been embarrassed with similar cases. Happily the cure of the patient had generally arrived to put an end to his doubts.

Castex: The diagnosis of tonsillar chancre is not always so easy as Moure believes. In epitheliomas with ulceration the differentiation may be very difficult.

—Journal of Laryngology, Dec. '95.

German and Italian

Translated by DR. F. E. CHANDLER.

ON THE IMPORTANCE OF CHINOSOL AS AN ANTISEPTIC.

Doctors Ahlfeld and Vahle, of Leipsic, have made a thorough clinical and bacteriological examination of this new product in the Lying-In-Hospital.

Twelve pupils scrubbed their hands in hot water and soap for five minutes, and used chinisol in solutions of 1-1000, 1-500, and, finally, of 3-100. The fingers were rubbed for three minutes with these solutions.

The hands thus prepared were then dipped in hot sterilized water and kept there for five minutes.

Forty-eight experiments made with these precautionary measures failed in only forty-seven cases, the exception being the pupil who had used the three per cent. solution, who alone had a finger totally free from all.

As chinisol had been claimed to be innocuous when administered internally, the authors made subcutaneous injections of this substance into rabbits.

Small doses of a weak solution caused the animals to weaken and present signs of great malaise. Stronger solutions, employed in the same way, proved lethal.

—Centralbl. f. Gynaek. I. M.

SPONTANEOUS CURE OF A RUPTURED UTERUS.

Dr. Queisner, of Bromberg, reports the following case. A woman, 38 years of age, had always had easy deliveries and gotten out of bed three days post-partum. Author was called the evening of January 18 to the patient and found that she had been in labor 24 hours without there having been any advance.

The next morning the patient said that something in her body had given way. Examination of the womb showed a longitudinal tear of 10 to 12 cm.

The right foot presenting, was replaced in the uterine cavity, delivery followed, and the placenta was detached with the fingers.

The following day the temperature was normal; a fortnight later the woman left her bed. The cause of the rupture of the uterus is not definitely established, but it was probably caused by the strain of lifting a sack of potatoes, the very day her labor pains commenced.

—Der Frauenarzt. I. M.

DIPHTHERIA OF THE EYE CURED BY THE APPLICATION OF WHEY.

Dr. Ewetzki, of Moscow, received in clinic a little girl who had an inflammation of the left eye.

The child was thin, pale, badly nourished, but did not give one the impression of suffering from a severe illness. The upper lid of the left eye was very much swollen, reddish and covered the border of the lower lid. The latter was also slightly swollen and exuded a cloudy liquid.

Turning back the lid revealed a membrane dotted with greyish-green spots. This film could be partially removed. The ocular conjunctiva was somewhat reddened. Membranes extruded from mouth and nose. Bacteriological examination showed bacilli that differed in no respect from those described by Loeffler.

Author treated child with antidiphtheritic whey; in two months' time the child was completely cured.

In another case reported by the author, a child 3 1-2 years old, had an inflammation of both eyes. In this case it was possible to trace the origin of the affection. A child in the house had just died of laryngeal diphtheria.

It is interesting to note that there was first an inflammation on the hands and was thus communicated to the eyes.

—Wratch.

CHANCRE OF THE CHIN.

Dr. Thibierge mentions a case of this kind and says:

"It is a well known fact that the initial syphilitic lesion may develop at any point on the skin and accessible mucous surfaces. Statistics show that from 7 to 8 per cent. of the primary syphilitic sores are extra-genital." The case in question was a chancre of the chin in a woman 36 years of age. She was ignorant of its origin. Widow for five years, she is sure to have had sexual relations with no one that was affected with any skin disease. As servant in a hotel she had noticed that the sheets of the beds that she made daily were often stained with pus and blood which must have been of genital origin. Possibly some little boil or slight scratch on the chin had opened the way to the syphilitic infection.

Had the patient been a man, we should have considered the possibility of infection by the barber's razor or shaving brush, but in the case before us these must necessarily be left out of consideration.

—Bulletin Medical. I. M.

PRECOCIOUS MENSTRUATION.

In our old friend, the *Independance Medicale*, we find the following, translated from the *Medical Record*. Not having seen it noticed, we take the liberty of putting it back into English:

Dr. Woodruff, of Auburn, reports a case of menstruation in a little girl

of six years and two months. Her face and general appearance resembled a girl 14 to 15 years of age. The breasts were full, firm and round; the mons veneris covered with hair; the hymen intact and the uterus normal.

The mother affirmed that the child had menstruated since her second year.

TREATMENT OF ECZEMA WITH STREAMING HOT STEAM.

Dr. E. A. Liberson.

L. observed that a stream of steam, 104-122 degrees F., directed on the affected portion of the skin, will remove the crusts and scales, increase the formation of dermo-cells, aid the absorption of the superficial and deeper eruptions of the skin, lessen or entirely cut short pus formations and call forth a strong new tissue formation even in places where chronic inflammation made healing rather difficult. The apparatus which author employed consists of a hermetically closed cylinder, made of heavy brass walls, containing 2-3 glasses, heated at the bottom by a spirit lamp. In the cover of a cylinder are two openings, one for admitting water, which is closed up with a screw cap, and the other for a tube bended in an angle, which is likewise tightly screwed in the cylinder. A rubber tube, half a yard long, is connected to the latter at the free end, a wooden hilt is placed. The end is brought close to the skin, depending to the sensitiveness of the patient from 6-10 inches. This, repeated at first every 1-4, later every 1-2 hour. Instead of pure steam this may be impregnated with various medications.

—Jushno-Russkaia Med. Gazeta, '95, No. 51-52.

Current Literature in Obstetrics and Gynecology.

R. D. KINNEY, M. D., Boston, Editor.

PLACENTA PREVIA.

Demelin (*Archives de Tocol et de Gynec.*, November, 1895) divides hemorrhage from faulty attachment of the placenta into three varieties. In the first labor has not begun. Here, if the flooding has been slight and has ceased, a skilled nurse should be constantly at hand ready with the tampon. When no assistance of this kind is available, the uterus should at once be emptied if the patient be strong with a good pulse. If she be weak from the hemorrhage, and therefore unable to bear so active a measure, the tampon should be introduced, and maintained till the patient is stronger. In about six or eight hours, as a rule, forcible delivery will be safe to perform. In the second class of cases labor has set in, but the cervix is but incompletely dilated. Then in lateral or marginal insertion of the placenta the membranes should simply be well opened if the vertex present, and be well engaged. This maneuver is dangerous if the pelvis be contracted. In breech presentation, well engaged, one foot must be drawn down through the rent in the membranes. In any other presentation, or when the vertex or breech is prevented from coming well down, the dilating bag should be employed after rupture of the membranes, as the presenting part cannot in such a case press strongly enough on the bleeding surface. The tampon may also be needed. In complete placenta previa, when the cervix is not fully dilated, the placenta should be perforated and the cervix dilated with the bags, the fetus being rapidly delivered if the patient be still strong. When she is weak, the pulse failing, the tampon must be applied till she has regained strength. If suddenly the child and the tampon are delivered together, so much the better. There remains the third class of cases. Here labor

has set in, and the cervix is completely dilated. To turn and deliver at once, or to deliver with the forceps if the head be well engaged, is the right course unless the patient be very weak from hemorrhage. In such a case as before dilatation or labor the tampon should be used. The head must be lowered, the extremities bandaged, warmth applied, etc. Rapid delivery must be effected, under ether directly the patient has regained sufficient strength.

—British Med. Jour.

PUERPERAL FEVER.

Rapin (*Revue Medicale de la Suisse Romande*, October 20, 1895) denies that there is such a thing as puerperal fever without local lesions. Practically the disease begins as septic endometritis. The acute so-called "unlocalized" form is always rapidly fatal, so that no clear naked-eye changes can be detected in the infected endometrium. In a few slower cases definite pyemic changes are observed; the disease is then rather acute septicemia or pyemia than fever. The chronic "unlocalized" form of puerperal fever is much milder; most cases of recovery belong to this type. The endometrium is always inflamed and septic, but the inflammatory process is locally mild, passing off before general symptoms are observed. The fever is due to intoxication, not infection. Toxins develop in the inflamed mucosa and pass into the blood. Microbes, Rapin insists, may enter the blood, but they are destroyed by phagocytosis or by the bactericide action of the blood, in this form of fever. Thus chronic puerperal fever, "without localization," is really chronic septic puerperal endometritis, the general rapidly replacing the local symptoms. The importance of the early use of the curette becomes evident.

—British Med. Jour.

PREGNANCY AND EXOPHTHALMIC GOITRE.

Signier (*Repertoire universel d'Obstetrique et de Gynecologie*, June 25, 1895) reports a case in which exophthalmic goitre began with a pregnancy, the symptoms ameliorating after delivery. He believes that the pregnancy was really the cause of the enlargement of the thyroid gland. Possibly the diminution in its size after parturition depended on some temporary condition in connection with the puerperium. Even so simple a cause as the necessary rest may explain the favorable change, which, after all, may not prove permanent.

—Univ. Med. Magazine.

STRYCHNINE IN PREGNANCY.

Olenyn (Protocol of the Medical Society of Tombow for 1894) has successfully used strychnine in 16 cases for the correction of weak labor pains in doses of 1-32 to 1-25 grain twice daily, at intervals, during the last six or eight weeks of pregnancy. Four of these cases were anemic primiparae from 19 to 23 years of age with weak muscles; three were multiparae under 30 years, with habitual weak labor pains; four suffered from chronic metritis and had been pregnant at intervals of from three to twelve years; one patient had a small uterine fibroid; two had flabby uterus and relaxed abdominal walls; one had tertiary syphilis and general debility, and another diseased appendages with hysteria. In two primiparae the forceps had to be used, and in one the child was dead; but in all the other cases delivery was rapid and regular and the children lived. The third stage lasted from ten to twenty minutes and post-partum contraction of the uterus was excellent.

—Univ. Med. Magazine.

VAGINAL INCISION AND DRAINAGE.

Long (*Int. Jour. of Surg.*, January, 1896), in citing the reasons for preferring the vaginal route, says:

1. Vaginal drainage is ideal drainage. Does the vagina not carry away the waste of each monthly period

and puerperium? The very structure of its epithelial lining, many-layered and resistant, makes it specially suitable for a drainage canal; the vaginal incision taps the septic focus at its base; the drainage is downhill; gravity aids capillarity; there is no coffee pot spout arrangement that requires to be sucked out with a long nozzle syringe at stated intervals.

2. There is less danger of further infections. To drain septic matter through the abdomen is always hazardous, no matter how careful your aseptic precautions.

3. The operation per vaginam is much easier to do.

4. There being little shock attending the operation, it may be done when the patient is in extremis.

He has performed this operation when the patient was too feeble to take anesthetic; it is truly a life-saving operation.

The dangers other than those incident to anesthesia are twofold—

1. Opening a viscus or blood vessel. This can be avoided by care. He always estimates the thickness of the upper part of the recto-vaginal septum by one finger in the rectum and one in the vagina. The median incision, just behind the cervix, very short and just deep enough to go through the vaginal wall, will obviate the danger of opening either viscus or vessel.

2. The second danger is that of opening the peritoneal cavity, thereby infecting the peritoneum. The same care and thorough asepsis will obviate this danger.

The writer has opened the peritoneum, while attempting to open a septic accumulation that was situated laterally, without doing harm.

TRAUMATIC STRICTURE OF THE VAGINA.

Holmes (*Jour. Amer. Med. Asso.*, January 11, 1896) reports the case of a woman, a bride of three days, who consulted him on account of unendurable pain at first attempt at coition. In her girlhood patient had fallen on a picket fence and injured the vagina and bladder, but she be-

lieved she had entirely recovered from this injury. Bloating somewhat at menstrual period but had no pain; always a rather long flow, sometimes lasting six or eight days. Clots were never seen. There had always been some leucorrhea. On examination the vagina was found closed just beyond the remnants of the hymen. A large tumor could be felt through the rectum about an inch and a half behind the stricture, and still further back the tumor verged into the uterus. The tumor was evidently cystic. Pressure upon it did not cause any discharge of its contents into the organ, and was not painful. The case was pronounced one of stricture of the vagina, with dilatation of posterior portion by discharges from the uterus.

Operation confirmed the diagnosis. About six ounces of pus-like fluid were discharged from the cyst when it was opened.

BACTERIOLOGICAL EXAMINATION OF THE FEMALE GENITAL SECRETIONS IN PREGNANCY AND THE PUERPERIUM.

Max Walthard (Arch. f. Gyn., 48 Band 2 Heft.) The results of the author's investigations are summarized in the following conclusions:

The vaginal secretions of untouched pregnancy contain not infrequently puerperal germs, viz, streptococci, staphylococci, gonococci, and bacteria coli. In 27 per cent. streptococci were found which could not be distinguished from the streptococci of the puerperium, except that they lacked virulence.

Of 100 cases in which the vaginal secretions were examined, in only 14 were Doderlein's observations confirmed. Acidity of the vaginal secretions does not exclude the presence of streptococci in condition to take on active development.

Fifty examinations of pregnant cases showed that the pure mucus of the cervical canal is not a culture medium favorable to the growth of bacteria. It acts in some degree as a bar to the bacterial invasion of the uterine cavity. The limit between

the bacteria-free and bacteria-containing part of the genital tract in a pregnant woman is found in the cervical canal.

Implantation of the morphological elements of the vaginal secretion in the otherwise germ-free cervix by manual exploration is possible, and in all examinations carried above the os externum without previous vaginal disinfection is probable. The germ contents of the vagina are diminished, but never wholly abolished by the flow of waters after rupture of the membranes.

The vaginal micro-organisms do not spontaneously invade the uterine cavity during the puerperium. The uterine infection occurs during labor. The dangers of high examinations (above the os uteri) are obvious.

The virulence of streptococci is not increased by cultures in liquor amnii. The innocuous vaginal streptococci acquired some degree of virulence in cultures made in lochia, but none to the extent observed in fresh streptococci from phlegmon or from the lochia of puerperal fever. The vaginal streptococci act as saprophytes (without virulence) causing simple resorption fever.

The vaginal streptococci can, like the intestinal streptococci, attain a parasitic character, if the resistance of the tissues in which they are found is lowered. The degree of virulence which the original streptococci then may attain, may equal that of the puerperal streptococci. Puerperal fever caused by vaginal streptococci is therefore to be excluded from the pathology of childbed.

The occurrence of puerperal fever (pure toxemia resorption fever) caused by vaginal streptococci of a saprophytic nature is to be avoided by preventing intrauterine infection, a danger always present in manual and instrumental operations.

The existence of puerperal fever caused by the virulent growth of vaginal streptococci in damaged tissue can be prevented, if in all difficult labors the vagina is thoroughly disinfected.

A prophylactic disinfection of the vagina during labor is indicated in

all cases before examination or operative interference above the os externum, in all irregular births, in all diseases which impair the general resisting powers, such as nephritis, uncompensated heart lesions, syphilis, diabetes, anemia, etc.

Brooklyn Med. Journal.

RADICAL RELIEF OF UTERINE FLEXIONS.

As an entirely new operation for the cure of flexions of the uterus, Nourse suggests the following, which seems to present many valuable features: The patient is prepared for the operation in the customary manner, by the proper use of iodine, resorcin, hot water injections, boroglyceride tampons, and gentle efforts are made to free adhesions if they exist, and at the same time to replace the organ. If endometritis be present, the cervix should be dilated and the curette used, followed by iodoform gauze packing. Firm adhesions, which will not yield by the milder methods, can be freed by some of the more radical procedures, such as laid down by Schultze and others. The uterus and surrounding structures being fully prepared, the operation is done as follows: The patient is placed in the dorsal position, with thighs flexed as usual. The vagina and cervix are made sterile, and a self-retaining speculum introduced; the author uses a piece of lead pipe worked into a proper shape, which he finds answers nicely. The anterior lip is grasped and threaded, and the posterior seized with forceps; the cervix is drawn as near to the outside as possible; the cervix is then split transversely, and the incision carried as near to the angle of flexion as possible. If hemorrhage is severe, the bleeding points must be secured; the circular arteries will usually be cut, but this does no damage to nutrition, as they anastomose freely with both the uterine and vaginal. The sound is next introduced with its concavity looking downward, until it reaches the fundus; the sound is now made to revolve half way upon itself, and at the same time the

handle is given a circular sweep in a direction that will tend to throw the fundus into its proper place and overcome the flexion. While the manipulation is taking place, traction should be made upon the anterior lip, which will greatly facilitate the above procedure, and at the same time put it on the stretch, so that when the lips are properly secured the fundus will be prevented from dropping back into its abnormal position. A double volsella forceps is now made to grasp the cervix as a whole, well forward, which will firmly sustain the relation of the lips to each other and prevent the uterus from falling backward and assuming its old crook until the stitches are put in place. During the stitching the sound should remain, and thus prevent closure of the canal, as the needle is made to puncture both lips at once. The stitches should not be removed under two weeks. If the anterior lip of the uterus project too far, it can be amputated. After all operations the vagina should be firmly packed, to both sustain the wound and at the same time prevent secondary hemorrhage. If at any time the uterine arteries are in danger of being cut, this can be avoided by incising the mucous membrane in their vicinity and crowding them out of the way. If adhesions are so firm that they cannot be broken up, operate, and by bringing the cervix into line with the body, straighten the canal, which will admit of free drainage. This operation should not be done in any case where evidence of pus pockets exists in the surrounding structures. Tumors, malignant growths, displaced and badly-adherent ovaries will debar it.

American Journal of Obstetrics.

A NEW POSTURAL METHOD OF TREATING PROLAPSUS OF THE UMBILICAL CORD.

A. Brothers in the course of a paper with the above title, says: The postural treatment for this unfortunate complication was first suggested by Thomas. The woman being placed in the genu-pectoral position, the

body of the uterus tends to sink lower than the cervix, and the replaced cord, owing to the same force of gravity tends to slip down to the fundus and out of harm's way. The position, however, is an arduous one for a woman in labor, particularly if it is to be kept up for any length of time. Over a year ago, while preparing the chapter on prolapse of the cord for the William F. Jenks Prize Essay, it occurred to me that the same result could be obtained in a far simpler manner, and with less discomfort to the patient and attendant, by raising the pelvis to a sufficient height with the woman on the back. At that time I wrote: "Theoretically the Trendelenburg position ought to be followed by the same result." Since that time Dr. Brothers has had three opportunities for testing the efficacy of the method. In the first, an ordinary cane chair was placed upside down at the foot of the bed and covered with a pillow and sheet. The woman was dragged up the incline on her back, so that the pelvis was several feet higher than her head. He now introduced the entire hand into the vagina, pushed the cord very easily into the uterine cavity, ruptured the membranes, and placed a new sponge against the late seat of the prolapsed cord. The presenting foot was next seized and delivered with a good portion of the breech. After some difficulty the second was brought down. As the child was presenting with its abdomen anteriorly—a threatening condition for the child—he seized both feet and rotated the body of the child on its long axis, so as to get the dorsum anteriorly. The chair was now removed and the patient dropped to the level of the bed, so as to facilitate further manipulations. In each of the other two cases Dr. Brothers elevated the pelvis by making use of the footpiece of the bed, which was about 18 inches above the plane of the bed proper, an incline being then quickly made with a washboard and an ordinary piece of board. These were covered with a pillow and the woman drawn up the incline so that the pelvis was elevated.

American Journal of Obstetrics.

CARE OF THE PERINEUM DURING DELIVERY.

Grandin and Jarman, in their excellent new book on Pregnancy, Labor and the Puerperal State, say that the teaching of "support of the perineum" has been of great harm as regards the maintenance of the integrity of the maternal soft parts. It is not the perineum which needs the support. It is the head which must be delayed in its progress until the muscular structures have relaxed, as they inevitably must unless diseased, and extension must be prevented until the proper diameter of the head has engaged at the outlet under the pubic arch. If anything is to be supported it is the fetal head, and the support given in the line indicated. In the normal case the perineum need not be touched. The authors then direct attention to a plate which shows the index finger in the rectum on the fetal chin, whilst the index and thumb of the other hand are pressing the sinciput downward and backward. By this means advance is delayed and flexion is promoted until the structures have yielded, and until the suboccipital point is engaged under the pubes. This accomplished, the patient is anesthetized momentarily to the surgical degree, and, in the interval between the pains, the head is shelled out over the perineum. * * *

The methods still figured of the "support of the perineum" should serve as warnings what not to do. The thumb applied to the head, and, if need be, the index finger inserted into the rectum, in order to enable the extension to be of the most gradual type, is the proper way to deliver the head, under normal circumstances. Stretching of the muscles of the pelvic floor should be avoided, since such action leads to increase in the action of the uterus and to spasm of the muscular structures of the floor.

Memphis Medical Monthly.

PHYSIOLOGICAL AND SURGICAL MENOPAUSE COMPARED.

Dr. Bloom in comparing two such dissimilar conditions as the natural

and surgical menopause says: The physical menopause is the normal cessation of a function which has fulfilled in the economy of the woman that condition which is necessary for the reproduction of the species; and is brought about by changes of a retrograde character in the uterus, tubes and ovaries.

The physiologic process of involution in the reproductive organs at the climacteric gives rise to the following physical signs which are directly opposite to those that take place at puberty.

The ovaries and fallopian tubes diminish in size and often become obliterated, the cavity of the uterus becomes smaller, the cervix decreases in size and often disappears. The dimensions of the vagina become very much contracted, especially in women who have not borne children and the mammary glands also participate in this atrophy. All these changes leading to the fourth epoch, or that cycle in a woman's life which ends maternity.

How directly opposite is the surgical menopause so far as the natural condition of the individual are concerned. In this form there is not only an abrupt termination of a function which has not fulfilled the period intended by nature, but also a state of the whole system which is not prepared for the absence of so important a phenomenon originally intended to be prolonged until senile changes in associated organs had abolished it.

The symptoms which are noted as belonging to the normal climacteric have their counterpart in the surgical menopause with this difference, that in the latter the symptoms are ten-fold more severe, and seem to be protracted to a much greater degree.

From a study of over 400 cases of hysterectomy, covering a period of six years, the conclusion derived from a comparison between the physiologic and surgical are as follows:

1. That the normal climacteric may be attended by mild or moderately severe symptoms, and that these are usually nervous phenomena.

2. That these symptoms frequently marks others less pronounced; con-

sequently organic disease is often overlooked.

3. As a physiologic condition nearing its end, any discharge over the normal amount demands an immediate examination.

4. An average of two years covers the duration of the usual symptoms attending this change.

5. The average age when menstruation ceases is about 43 years and 8 months, the oldest in the series to complete her menstrual life being 54, the youngest 29; the average menstrual life being 29 years and 3 months.

6. That there is no positive relation between an early puberty and a late menopause.

7. As to the sexual sense of women after the menopause, it is surprising to learn that this life sometimes is not dead at a far advanced age.

Of the surgical form, the nervous phenomena as before noted are ten-fold more severe.

It can be set down as a truth that the nerve-storm is so great in some of these women that something must give way; and if there is a systemic predisposition, we find coincident organic disease very much more frequently than after the natural menopause. It is also observed that these diseases are more frequently lesions of the nervous and vascular systems.

As a rule, disease in this class of women is hard to treat, and yields slowly and unsatisfactorily to all therapeutic measures. Hemorrhage or discharge is less frequent. As to the length of time before these phenomena cease, it can be accurately stated they will invariably be much more protracted, even in some cases covering a period of years.

There appears to be no difference in the sexual life of these women prior to 33 years of age. After this age where hysterectomy has been done, it is notably lessened, and in many cases abolished. In other sexual characteristics there is no difference; the breasts do not lose their shape, they do not become fat, and there is nothing about them to indicate masculinity.

Union Med. Magazine.

Current Surgical Literature.

T. H. MANLEY, M. D., New York, Editor.

PREHISTORIC TREPHINING.

Mr. D. G. Brunton, writing in *Science*, calls attention to an article by General Von Krahmer in the *Globus*, Bd. lxvii, No. 11, in which he describes an amulet obtained in 1883 from a neolithic burial in Russia. It was of bone, and on examination proved to have been taken from a human skull. Ten years later the archaeologist Bieilachewski, in exploring a deposit on the banks of the Dnieper, exhumed a human skull from which a precisely similar fragment must have been removed. Careful inspection showed that the trephining had been performed after death, the spot selected for the operation being the right frontal bone. The instrument must have had a sharp cutting edge, but there is evidence of lack of skill in the use of it. The skull must have belonged to a comparatively young person, probably a woman. Such examples are said to be extremely rare in Russia. Among the skulls in the Anthropological Museum of Moscow there is but one showing evidence of ancient trephining, and it is catalogued as coming from the Caucasus. The evidence brought forward by General von Krahmer showing that this operation was occasionally practiced in order to obtain amulets from the parietes of the skull is valuable as illustrating a primitive superstition which prevailed in several widely-separated tribes.

—British Medical Journal.

AN AID TO GENERAL ANESTHESIA.

Gerster has reported in the *Annals of Surgery* the results of observations made with Mayer and Theobald on one hundred cases of anes-

thesia, in which it was found that if a preliminary application of a ten per cent. solution of cocaine were made to the nasal mucous membrane, the distress and oppression felt by the patients during the first part of the anesthesia were considerably diminished. In almost all the cases—excepting those of confirmed alcoholics—there was less reflex irritation manifested than usual. Insensibility occurred more rapidly and more quietly, and with less coughing, straggling and nausea; especially when ether was used. The later stages of anesthesia were also less disturbed than usual by interruptions. In some cases, in from twenty to twenty-five minutes after the first application of the cocaine, a marked acceleration of the pulse-rate and facial pallor was observed, followed by profuse sweating. Gerster believes that the patients suffered less from nausea, vomiting, headache and general malaise, after the anesthetic. Some few patients who did not vomit at all during the first twenty-four hours vomited a good deal on the second and third day. Gerster concludes that, on the whole, in view of the ease and simplicity of the procedure, of the absence of apparent risk, and on account of the undeniable diminution of the trying subjective effects upon the patient caused by the use of cocaine upon the nasal mucous membrane, it deserves extended trial. Anesthetists who read this would do well to make further observations.

REIMPLANTATION OF TEETH AFTER COMPLETE TRAUMATIC DISLOCATION.

My little daughter, aged two years and nine months, fell headlong down the cellar stairs and struck the two

upper middle incisors on the edge of the step, extracting them as completely as if by forceps. The alveolar process of the right tooth was fractured, and the gum lacerated the entire length of the root. We found both teeth lying uninjured on the cellar steps. They were placed in a normal saline solution of tepid temperature. On the arrival of an assistant with chloroform the child was sleeping quietly. Chloroform was administered without the child awakening, and the teeth were placed within their sockets and pressed into position. The gums were cleansed antiseptically and the teeth left in position without further dressing or application. The teeth had been out of the mouth fully one hour. Milk and soft food were administered, and the lacerated edges of the gums cleansed after eating. It is now over four weeks since the teeth were placed, and they are perfectly solid, in good position, and of normal color. The gums are normal in color and consistency, and the appearance of the mouth quite natural. I report this as a successful case of implantation of teeth that had been out of the mouth over an hour, and as another demonstration of chloroform anesthesia during natural sleep.

—E. T. Pettyjohn, M. D., Chicago
Chemical Review, January, 1896.

VENESECTION IN CHLOROFORM POISONING.

In reading the constantly recurring accounts of death from chloroform, I have never noticed that bleeding the patient has been tried. As a rule, in these reports there is no account of a post-mortem examination, but in some I have noticed that the left ventricle is stated to have been empty and the right full. It strikes me that if the engorgement of the right side could be relieved there would be a much greater chance of the patient's recovery; and this can be done by venesection, which, if desired, might be supplemented by galvanism to stimulate the heart's action. No harm, at any rate, would be done by bleeding, as none of the usual remedies have any

beneficial effect, the patient always dying if the pulse ceases before the respiration. I should recommend opening the jugular vein as more directly relieving the heart.

Many years ago, when I was house-surgeon at the Children's Hospital, Shadwell, I noticed that at the post-mortem examinations of children dying from morbus cordis, the right side of the heart was engorged and the left empty, although just before death the child had been pale and not at all cyanotic. I determined to bleed in the next case of impending death from this cause. A few nights later I was called to a child with morbus cordis—I forget the particular form—and found him pale, pulseless, and apparently in extremis. I opened the jugular vein, and with difficulty got the blood to flow, but after a very little blood had come the patient roused up and seemed much relieved; by the next morning he was quite himself again.—F. H. Spooner, *The Lancet* (London).

THE OPERATIVE TREATMENT OF WRY NECK.

Mikulicz (*Centralblatt für Chirurgie*, 1895), being dissatisfied with the results both of subcutaneous and open division of the sterno-mastoid in cases of wry neck, advocates almost the total removal of the contracted muscle, the posterior part of the upper extremity, where it is traversed by the spinal accessory nerve, being left. He has operated upon seventeen cases with success, the only bad results being the disfigurement of the neck caused by the absence of the muscle. Examination of the extirpated muscle in these cases has convinced him that wry neck is the result of a chronic inflammatory condition (*myositis fibrosa*) involving the whole of the sterno-mastoid muscle. This condition he attributes in congenital cases to compression of the muscle during a long, difficult labor than to laceration. The so-called hematomata of the sterno-mastoid sometimes observed in infants is not due to effusion of blood, but to thickening and induration of the inflamed muscle.—*University Med. Mag.*



Miscellany.

PURE BEER.

Beer has been the subject of legislation from a very early time, and, contrary to what many believe, was adulterated in the old days as much as it is now, though in quite a different way. "And you, maister brewer, that groweth to be worth 40,000 pounds by selling of soden water, what subtilty have you in making your beer to spare the malt, and put in the more of the hop to make your drink, be barley ever so cheap, not a whit the stronger, and yet never sell a whit the more measure for money. You can, when you have taken all the harte of the malt away, then clap on store of water ('tis cheap enough) and mash out a turning of small beer like rennish wine; in your conscience how many barrels draw you out of a quart of malt?" So was it written in a curious tract published in 1592. According to those who are supporting by petition Mr. Cuthbert Quilter's endeavors to introduce a Pure Beer bill on the 25th inst., the question, How many barrels draw you out of a quarter of malt? would still be an awkward one for some "maister brewers" to answer. Not, however, because malt is used sparingly, but not at all. Sweet wort may consist of the sugars obtained from certain starches by the hydrolising action of weak boiling acid. The weak saccharine solution may then be fermented and subsequently bittered with anything but hops. The resulting product, therefore, is not a malt liquor or such a wholesome bitter as if it contained hops. In short, it is not beer; no liquor should be described as such that is not brewed exclusively from barley, malt and hops. We trust that the petitioners who are now humbly praying that such a definition may shortly become law will have their petition granted.

—Lancet.

PRELIMINARY PROGRAMME OF THE TENTH ANNUAL MEETING OF THE AMERICAN ORTHOPEDIC ASSOCIATION.

To be held at Buffalo, May 19, 20 and 21, 1896. Dr. John Ridlon, Secretary, 103 State street, Chicago.

The President's Address, by Dr. Royal Whitman, New York. Some practical points in the treatment of Lateral Curvature of the Spine, by Dr. A. B. Judson, New York. Some etiological factors in Lateral Curvature of the Spine, by Dr. E. G. Brackett, Boston. Cases illustrating the absurdity of treating ordinary Lateral Curvature (Scoliosis) by Spinal Supports, by Bernard Roth, F. R. C. S., London. The rationale of Gymnastic Exercise and Pressure Correction in the treatment of Scoliosis, by Dr. L. A. Weigel, Rochester. The rapid cure of Rotary Lateral Curvature of the Spine and other postural deformities by means of thorough development, and corrective exercise with heavy weights, with a demonstration of the method, by Dr. Jacob Teschner, New York. A simple and efficient brace for Lateral Curvature, by Dr. S. L. McCurdy, Pittsburg. Congenital Misplacement of the Femur anteriorly, by Dr. DeForrest Willard, Philadelphia. Further remarks on Congenital Dislocation of the Hip, by Bernard E. Brodhurst, F. R. C. S., London. Report of a case of double Congenital Dislocation of the Hip, treated by the Lorenz method of operation, by Dr. Reginald H. Sayre, New York. The Cure of Congenital Dislocation of the Hip by means of the "functional weighting" method, without open operation, by Dr. Adolf Lorenz, Vienna. Spontaneous Dislocation of the Hip, by Dr. William J. Taylor, Philadelphia. The treatment of Club-Foot—(a) When to commence treatment and how; (b) the indica-

tions for mechanical treatment; (c) the limitations of mechanical treatment; (c) the indications for operative treatment; (e) results in 343 operations performed by the writer, by Dr. A. M. Phelps, New York. Investigations on Flat-foot, by Dr. E. H. Bradford, Boston. Mechanical Support for Flat-foot, by Dr. John C. Schapps, Brooklyn. The Anterior Transverse Arch of the Foot, by Dr. Joel E. Goldthwait, Boston. Injuries of the Tarsus and the Ankle Joint, by Dr. J. D. Griffith, Kansas City. Subtendinous Exostosis, by Dr. E. G. Brackett, Boston. The mechanical treatment of Ingrown Toe Nail, by Dr. Henry Ling Taylor, New York. The operative treatment of Paralytic Deformities of the Foot with particular reference to Arthrodesis, by Dr. V. P. Gibney, New York. Some mechanical problems in the treatment of Pott's disease, by Dr. John C. Schapps, Brooklyn. The operative treatment of threatening abscesses in the high dorsal region, by Dr. E. H. Bradford, Boston. The treatment of Pott's Paraplegia with a report of two cases, by Dr. Le Roy W. Hubbard, New York. Osteomyelitis of the Spine, by Dr. T. Halsted Myers, New York. Suppuration in Joint and Spinal Disease and its relation to Tubercular Meningitis; an Analytical study, by Dr. Samuel Ketch, New York. A study of the action of Iodoform Glycerine in tubercular osteomyelitis, by Dr. Harry M. Sherman, San Francisco. Joint disease in Infancy, by Dr. Augustus Thorndike, Boston. The use of Dry Heat of high temperature in the treatment of Chronic Joint Affections, by Dr. William E. Wirt, Cleveland. A theory of the Ultimate Etiology of Deformity and its practical application, by Dr. Royal Whitman, New York. The probable cause of the limp in the first and second stage of Hip Joint Disease, by Dr. Harry M. Sherman, San Francisco. Femoral Osteotomy for correction of hip deformity in adults, with a report of cases, by Dr. A. R. Shands, Washington. A report of cases of Osteosarcoma of the Hip, by Dr. Arthur J. Gillette, St. Paul. Division of the

hamstring tendons by the open method for correcting malposition and securing rest in Tubercular Disease of the knee, by Dr. Bernard Bartow, Buffalo. Tuberculosis of the wrist and carpus, by Dr. James E. Moore, Minneapolis. Symptoms and treatment of Slight Knock Knee in children, by Dr. Robert W. Lovett, Boston. Two cases of Dislocation of the Patella treated by operation, by Dr. Joel E. Goldthwait, Boston. Some notes on Spastic Paralysis in children, by Dr. F. S. Coolidge, Chicago. Some recent modifications in the treatment of Congenital Wry Neck, by William Adams, F. R. C. S., London. Contracted Fingers, by Dr. Arthur J. Gillette, St. Paul. Congenital Club Hand, the report of a case treated by operation, by Dr. C. E. Thomson, Scranton. Rare cases from Practice, by Dr. A. J. Steele, St. Louis. A report of some cases of unusual Congenital Deformities, by Dr. John Ridlon, Chicago. Congenital defects of the long bones, a report of cases and operations, by Dr. B. E. McKenzie, Toronto. Deformities of the Humerus due to Rickets, by Dr. Augustus Thorndike, Boston. A report of a Family of Anomalies, by Dr. S. L. McCurdy, Pittsburg. Readers will please prepare abstracts of their papers, in order that the proceedings of the meeting may be satisfactorily reported.

THE PHILADELPHIA COUNTY MEDICAL SOCIETY AND THE AMERICAN MEDICAL ASSOCIATION.

At a business meeting of the Philadelphia County Medical Society, held on April 15, 1896, the following preamble and resolutions were adopted:

"Whereas, The American Medical Association completed its organization and commenced its actual existence in the city of Philadelphia during the first week of May, 1847;

"Resolved, That a committee of three be appointed by the chair to publicly urge that the association celebrate in 1897 its fiftieth annual

meeting with ceremonies appropriate to its long and successful career.

"Resolved, That the delegates of the Philadelphia County Medical Association at Atlanta be instructed to extend to the association a cordial invitation to hold its semi-centennial meeting in Philadelphia, the city of its birth."

Accordingly, the president of the society, Dr. J. C. Wilson, Dr. John B. Roberts, and Dr. W. M. Welch were constituted a committee to effect the purposes of the resolutions.

GIFT OF \$100,000 TO HARVARD.

A prominent Boston merchant, who declines to have his name published, has given \$100,000 to Harvard University to establish a new department—that of comparative pathology. The value of the gift is augmented by the fact that this will be the first establishment of a professorship of comparative pathology in any of the great universities of America.

The professor is to be a member of the medical faculty of Harvard College, and is to study the conditions and causes of disease in both men and animals, and the means of avoiding and curing disease. He is to devote himself to the duties of his professorship, without engaging, as a rule, in private practice.

ABDOMINAL SECTION IN A CHILD NINE MONTHS OLD FOR OBSTRUCTION OF THE BOWELS; RECOVERY.

For twenty-nine hours before the operator saw the patient there had been no movement of the bowels, and the child had vomited. The lower bowel was easily washed out and inflated, and the tumor which was easily made out in the right iliac region, was reduced about one-half. Not being able to reduce the tumor completely by the various means tried, abdominal section was done. The invagination had taken place at the ileo-cecal region. Slight adhesion had formed, but reduction without laceration of the parts was

possible. The child made a good recovery.

—British Med. Journal.

REWARD FOR THE DISCOVERY OF A CURE FOR TUBERCULOSIS.

It is said that Mme. Audriffred has given to the Paris Academy of Medicine a sum equivalent to \$160,000, on condition that the same be securely invested and the income be paid yearly to the man who discovers a specific remedy for consumption, whether Frenchman or a foreigner, when it can be definitely decided that such a remedy has been discovered.

RESUSCITATION FROM CHLOROFORM.

Is effected by the Konig-Maas method as follows: The operator, standing on the left side of the patient and facing him, places the ball of the thumb of the opened right hand upon the patient's chest, at a point between the apex beat and the sternum. He then repeatedly presses in the thoracic wall with a quick, strong movement, at the rate of thirty to one hundred and twenty times to the minute. The efficacy of the method lies in its direct action on the heart, restoring not the respiration only, but the circulation also. If on a fresh cadaver the precordium be quickly and forcibly compressed, it is easy to detect a distinct pulse wave in the carotid arteries; and the pupils will be found to contract as the blood fills the capillaries of the iris. —Sanitary Era.

HOW THE COUNTRY BOYS MANAGE.

Scene first, country schoolroom.—Young lady teacher—"Tommy, you had better go out and wash your face." Scene second, the room two minutes and a half later.—Young lady teacher—"Tommy, you've washed your face pretty well, but you've not wiped it very nicely; your forehead is all wet."

Tommy (loudly, being aggrieved at unappreciated efforts)—"Wiped it as high as my shirt 'ud reach!"

A NEW RUBBER FOOT.

An improvement has been made recently in artificial feet which seems to leave nothing more to do in order to produce as nearly a perfect counterfeit of the natural member as it is possible for human ingenuity to secure.

The original rubber foot with stiff ankle joints was a vast improvement over the old style of wooden foot with articulating joints. The rubber reduces the shock and gives an elasticity of movement, while the absence of the ankle joint removes the old clanking and the uncertainty of movement incident to this mechanism.

Subsequently Mr. A. A. Marks, the original inventor of rubber feet, introduced an improvement which while very simple was of great value. It consisted simply of a longitudinal canvas, inserted from heel to toe near the bottom of the foot, the result of which was that the toe was drawn back to place and kept from mashing or turning up. This foot with the canvas brace was the standard for 15 years, but is now superseded by what seems to be the best possible change that can be made for the better.

The new invention consists of the insertion of a mattress of canvas in which is imbedded side by side a layer of narrow, flat, steel springs. The canvas holds them in the pocket, in which they slide freely, and the ends are capped with metal to prevent their perforating the rubber and leaving their proper bed.

The rubber which rests above this mattress is spongy, containing, therefore, a large percentage of air, increasing the lightness and also the flexibility of the foot. Further, just above the posterior end of the mattress in the heel there is a large air chamber so arranged that it cannot burst, and thus preventing the heel from matting or failing in elasticity.

The operation of this steel spring mattress is to throw the toe back as it is bent in walking, and thus to materially assist in locomotion.

This mechanism has been submitted to the most severe mechanical test, and found to be so durable that after being tested equal to 10,000

miles of actual walking it showed no signs of giving way.

By this improvement the foot is also lightened, and now weighs from eight to sixteen ounces less than any other made, varying according to the weight of the person wearing the limb. A. A. Marks, 701 Broadway, N. Y., is the sole proprietor of this artificial foot.

Dr. Francis J. Quinlan has been appointed laryngologist and rhinologist to Saint Vincent's Hospital in New York city.

ILLINOIS CENTRAL HOSPITAL FOR THE INSANE.

I have repeatedly prescribed anti-kamnia for various neuroses with good effect. Recently prescribed it in a case of croupous enteritis, patient adult, highly nervous, and during continuance of paroxysms, and preceding it, is nervous and hypochondriacal, suffering intense pain. The case is one of long standing, and one where opium was objectionable, because of the tendency toward forming opium habit. However, opium has been used, but the effect of anti-kamnia has been more magical, more persistent, and followed by no digestive disturbance, as has been the case when opium was used.

My directions have been to use anti-kamnia whenever a paroxysm occurs. Have also found it invincible in protracted neuralgia.

FRANK P. NORBURY, M. D.
Jacksonville, Ills., September 19, 1891.

CATARRH.

Chronic catarrh of the mucous membrane is often relieved by alkaline diuretics.

SENNA.

This drug is valuable in the incontinence of urine of locomotor ataxia.

Dr. Cantrell advises the use of lactic acid for the removal of the so-called venereal warts, and in making this remark he stated that it did not matter in what position they were found.—Phila. Polyclinic.

Therapeutical Progress.

BRIEF NOTES ON NEW AND RARE REMEDIES.

From the American Druggist.

MERCURY THYMOLATE.—Colorless or reddish powder, odorless or with faint thymol odor.

MERCURY THYMOLACETATE.—Colorless crystals, insoluble in water. Antisymphilitic. Intra-muscular injection 1-12 to 1-2 gr., also in pill.

METHACETIN. (Para-acetanisidine-Para-oxymethyl-acetanilid.)—Lustrous, colorless, or reddish, odorless scales. Almost insoluble in cold water; readily soluble in hot water, A., C., glycerine and fatty oils. Antipyretic, principally in children. Dose for children 2 to 4 grs.

METHOZINE.—Synonym for antipyrine.

METHYL CHLORIDE.—Gas at ordinary temperatures; tubes of the gas liquefied under pressure are used. The nozzle of the tube being opened the fine stream that issues is directed against a tampon of wool or cotton covering the area to be anesthetized (Sciatica, lumbago, intercostal neuralgia and minor surgery.)

METHYLAL. (Methylene-dimethyl-ether.)—Limpid, colorless liquid, with penetrating ethereal odor. Soluble in water, A., E., oils. Not inflammable. Local anesthetic hypnotic, sedative. Dose, 60 to 75 mins. in syrup. Locally as liniment (1 to 6 in olive oil.)

METHYLENE BLUE. (Tetra-methylthionine chloride.)—An aniline derivative. The medicinal is free from the zinc present in the commercial dye. Small blue-bronze, scaly crystals, slightly soluble in water. Analgesic, anodyne (neuralgia, rheumatism). Antiperiodic (malaria). Dose, 1 to 4 grs. 5 times daily in capsules. Hyp. inj. 1 gr.

METHYLENE CHLORIDE. (Dichlormethane.)—Colorless liquid, resembling chloroform in odor and solubilities, though rather more inflammable. Substitute for chloroform, but less safe; also as spray for local anesthesia. (Do not confound with "English methylene chloride," or "methylene," which is a mixture of ethyl ether and methylene chloride. A mixture of chloroform and methyl chloride has also been known in commerce as mythylene chloride.)

MICROCIDIN. (Sodium Beta-naphtholate.)—Whitish powder, soluble in 3 W. Antiseptic (wounds, ozena, rhinitis, etc., 0.3 to 0.5 per cent. aqueous solution.) Antipyretic.

MIGRANIN. (Citrate of Caffeine and Antipyrine.)—Caffeine, 8.2, antipyrine, 89.4, citric acid, 0.56 per cent. Analgesic, antineuralgic, specific in migraine. Dose, 17 grs., repeat if necessary in two hours.

MOLLIN.—Super fatted soap with 17 per cent. of excess of fat.

MORPHINE BORATE, and also the phthalate have been recommended for subcutaneous injection.

MORRHODOL.—Alcohol extract of cod liver oil; brownish yellow, oily liquid; bitter, acrid taste. Same uses as cod liver oil. Dose, 5 to 15 min., in capsules.

MUAWIN.—Glucoside from the muawí tree of Mozambique. The action resembles that of digitalin.

MYDRIN.—Mixture of the alkaloids ephedrin and homatropin; white powder, soluble in W. Rapid mydriatic in ophthalmology.

NAPELLINE.—From aconitum napellus, white powder, soluble in water, A., E. Anodyne, analgesic. (Neuralgia, rheumatism, etc.) Dose, 1-8 to 1-2 gr.

NAPHTHOL CARBOXYLIC ACID.

—Colorless crystals, sparingly soluble in water, but soluble in alcohol and alkalies. Antiseptic and disinfectant useful in scabies and analogous troubles. In solution about 1-2 or one per cent. is used; 10 per cent. ointments are employed.

NAPHTHOL, ALPHA.—White or reddish prisms, disagreeable to the taste; soluble in A., E., hot water, slightly so in cold water. Antiseptic, chiefly used in the arts. Recrystallized.

NAPHTHOL, ARISTOL. (Di-iodo-beta-naphthol).—Recommended as an antiseptic. Has attracted but little attention.

NAPHTHOL BETA.—White or yellowish scales. Readily soluble in A., E., C., B., oils and alkalies, sparingly so in water. Antiseptic, antifermentative. Cutaneous, parasitic affections (scabies, tinea tonsurans, etc.) Applied in 2 to 10 per cent. ointment or solution. Dose, 3 to 8 grs. Preservative for anatomical preparations.

NAPHTHOL, CARBOXYLIC ACID. (Alpha or Beta) Oxynaphthoic Acid.—Colorless acicular crystals. Sparingly soluble in water, soluble in 10 A., and alkalies. Antiseptic, disinfectant. Applied in 1-2 to 1 per cent. solution (scabies, etc.), or 10 per cent. ointment.

NARCEINE HYDROCHLORATE.—Shining crystals, difficultly soluble in water, easily in A. Hypnotic, anodyne, sedative. Dose, 1-8 to 1 gr.

NEURODIN. (Acetyl-para-oxy-phenyl-Urethane).—Colorless, odorless crystals, slightly soluble in cold water, easily in hot water. Antipyretic (typhoid fever, scarlatina, etc.), analgesic (neuralgia, migraine, etc.). Dose, 8 to 25 grs.

NOSOPHENE. (Tetra-iodo-phenolphthalein).—Yellow, odorless, tasteless powder. Insoluble in W., soluble in E., C. Forms soluble salts with bases. Contains 60 per cent. iodine. Non-toxic locally in ozena, etc.

NUCLEIN.—An extract of calf's milt, yellowish white powder, solu-

ble in alkaline fluids. Diagnostic for tuberculosis. Dose, 30 to 45 grs. per or half that subcutaneously.

OLEO-CREOSOTE.—Combination of beechwood creosote with oleic acid. Straw colored oily liquid containing 35 per cent. combined creosote, same indications as creosote and said to be borne better in large doses. Dose, 3-4 to 21-2 drachms daily. Also subcutaneously.

OLEO-GUAIACOL.—Combination of guaiacol with oleic acid. Same indications as guaiacol.

OLEITE.—Jelly-like ointment base formed by the action of sulphuric acid on castor oil.

OREXIN. (Phenyl-dihydro-chinazolinone).—Originally the hydrochloride was used, but the pure base is now put up as orexin. Appetizer in phthisis, chlorosis, cardiac diseases, nausea of pregnancy, etc., and after major surgical operations, in absence of gastric disease. Dose, 4 grs. 3 times daily in wafers in draught of bouillon.

ORTHO-CRESOL.—See Trikresol.

OUABAIN.—Glucoside from the wood of *Acocanthera ouabain*, also from the seed of *Strophanthus glabrus*. White, odorless, feebly bitter crystals, slightly soluble in cold water. Sedative (whooping-cough). Dose, for children, 1-1000 gr. every 3 hours.

OXYTOLUIC ACIDS.—See Acids, creosotic.

PAPAIN.—Digestive ferment from *Carica papaya*. Amorphous, whitish powder. Internally as an aid to digestion, externally in the removal of the false membranes of croup, tenicid, etc. Dose, 1-2 to 8 grs. in pill, powder, wine or syrup.

PAPAVERINE HYDROCHLORIDE.—From opium. Intestinal sedative (diarrhea of young children), 1-12 to 3-4 gr. 3 times a day.

PAPOID.—Digestive ferment from *Carica papaya*. White powder. Internally as an aid to digestion (dyspepsia, etc.), externally to remove false membranes (croup, diphtheria) and diseased tissue. Dose, 1-12 to 8 grs.

(To be Continued.)

Prescriptions.

FOR ACUTE CORYZA.

R. Chloralisgr. x
Olei ricinif dr iv.

Sig. Apply to the cleansed nasal mucous membrane.

—Pract.

PURULENT OPHTHALMIA.

R. Hydrastis sulphatis.
Acidi borici,
Sodii biboratis.....aa gr. v
Tinct. opii deodor.....oz ss
Aque destoz. j.

To be used as a collyrium from the beginning.

—Scott, Medical Times.

CANNABIS INDICA FOR ITCHING.

Mackenzie declares Indian hemp will give relief in the itching of skin disease not amenable to local treatment. The full effect of the drug must be produced promptly. He employs the tincture in doses of five or ten drops on sugar, repeated as often as is necessary.

—Am. Pract.

SOLVENT FOR SORDES.

Dr. MacGregor recommends:

R. Boric acidgr. xxx
Potassium chlorategr. xx
Lemon juicedr. v
Glycerinedr. 3 iij.

When the teeth are well rubbed with this the sordes easily and quickly become detached; little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria, and the chlorate of potassium cools and soothes the membrane; the glycerine and lemon moisten the parts and aid the salivary secretion.

—British Medical Journal.

CHRONIC RHEUMATISM.

R. Liniment aconiti.
Liniment belladonnæ..aa dr. ii.
Glyceriniad oz. ii.

Sig. Apply over the seat of pain.

—Fothergill.

ALOPECIA.

R. Ext. pilocarpi (fluid)....oz. i.
Tinct. canthardisoz. ss
Lin. Saponisad. oz. iv.

Sig. Rub into the scalp daily.

—Bartholow.

DANGERS OF COCAINE.

Dr. De Havilland Hall recommends the addition of resorcin to cocaine solutions for application to mucous surfaces. He finds it counteracts the poisonous effects of the cocaine and ensures the keeping properties of the solution. He usually employs a solution containing twenty per cent. cocaine and ten per cent. resorcin, and applies it by means of a piece of absorbent wool, never by spray.

—Brit. Med. Journ.

MALARIAL HEMATURIA.

Keeping the bowels open with calomel, followed by salts, Dr. J. E. Long, of Abbeville, Ala., uses hot mustard baths and administers the following combinations in alternation every three hours:

R. Spirit turpentdr. ij.
Acidi carbolgr. x.
Pot. chloratdr. iij.
Spirit lav. comp.....dr. ij.
Acacia gumdr. iij.
Aqua menth. pip., q. s. ad. oz. iv.

M. Ft. Sig. Teaspoonful every three hours.

—Louisville Medical Monthly.

BRONCHITIS IN THE AGED.

R. Benzoic acidgr. ivss.
Tannic acidgr. ii¼.

M. For one cachet.

Sig. Take four or five such cachets per diem.

—La Progres Medical.

For pruritis vulvae.

Pure morphine sulfate, 6 grains.
Boric acid.....1½ drams.
Camphor water.....6fluidounces.

Mix.

Apply locally.

—Phila Polyclinic.

For Physicians' Wives

DIET AND DIGESTION.

Much cold water should not be drunk during or after a meal. It chills the stomach and prevents proper digestion. The process of digestion can only be carried on at a temperature of about 98.

No man can lay down a rule of guidance for another man's stomach. Every stomach is a law unto itself. There are chronic dyspeptics who digest pork and beans better than any other food.

Foods are divided by chemists and physiologists into three classes: 1. Those which supply energy and replace exhausted tissue. 2. Those which supply only energy. 3. Those which only repair wasted tissue.

While digestion is going on there is a much greater flow of blood to the stomach than usual. Some physiologists calculate that ten times as much blood is required during digestion as at any other time.

An unvitiated appetite is the best guide in regard to what is safe to be eaten. A wild animal never makes a mistake in its diet; domesticated animals, in consequence of artificial feeding, may occasionally do so.

Dry bread is much easier of digestion than fresh. It is estimated by physiologists that over 10 per cent. of dry bread undergoes salivary digestion while being masticated, while of fresh bread less than 2 per cent. is thus charged.

Professor Sticker has demonstrated that the presence of saliva in the stomach promotes digestion. The same effect is not produced by water taken with the food. Therefore, the necessity of thoroughly chewing the food.

Meats, eggs and fish are almost the perfection of food. Of themselves they will sustain life for a considerable time, and with the addition of bread and butter, or one or two fruits or vegetables, will do so indefinitely.

A COUGH CURE(?).

How a cough is cured in Kansas may be of interest to all, even if the cure be not imitated. The writer of the paper, while passing his vacation at Manitou, the Mecca of America, was consulted by a vigorous, blue-eyed, light-haired Swedish girl of twenty-six summers, on account of a cough and various nervous disturbances.

The cure was as follows: First of all the lady must reside in the same house with the physician. Then came phosphate of iron, chloride of potash, galvanization of the body, faradization and dilatation (!) of the rectum. There followed galvanization of the solar plexus and of both vagi, nasal sprays, verbascum oil in the ears, and finally excision of the hymen and further dilatations and faradizations as already described, together with regulation of the diet and inhalations of oxygen, and the cure burst in upon this treatment like an avalanche in the mountains of the moon or an earthquake in the Sierra Nevadas. A poem by an unnamed writer closes this medical history.

—Medical Age.

CHILDREN'S MEALS.

When children are old enough to go to school they are old enough to be promoted from the milk and grain diet of earlier days. But until they

have attained their growth they should not be allowed the food of adults without careful eliminations. Tea and coffee should not be permitted to them and pastry should be very rarely allowed.

For breakfast children may have fruit, preferably raw, whole grain bread, fresh meat or eggs and milk. Cooked-over meat is not easily digestible. Cold meat may be warmed for breakfast in some way, but it should not be again brought to the boiling, baking or roasting point.

Luncheon should be equally simple and wholesome. It is better, in the case of young children, to serve a midday dinner to them, giving them soup, meat and vegetables, green salad and a light dessert. If it is merely luncheon that is served, it should be somewhat lighter, but still substantial enough to nourish the most active members of society through the afternoon. In the evening light foods are desirable. Clear soup, omelet, toast and cooked fruit form an admirable late dinner or supper for children. They should never be allowed heavy puddings, pies, meats or raw fruits at night.

—N. Y. World.

HOUSECLEANING TACTICS.

When the housekeeper who has cleaned her dwelling from the garret down reaches the first floor she has almost arrived at the end of her trials. She has only to remove a few carpets and rugs, attend to the renovating of a few floors, superintend the cleaning of bric-a-brac and silver, and her spring cleaning work is practically over.

If the rugs need more than a thorough beating and airing, it is wise to send them to the cleaner's. They may be cleaned at home, though the process is a rather tiresome one. If they are disfigured by grease spots, powdered magnesia piled on the stains may prove efficacious. After it has been allowed to remain awhile it should be brushed off. Other stains may be removed by vigorous rubbing with a cloth wet in ammonia and water, but care must

be taken not to soak the fabric itself. If the floor is of hard wood it may be polished brilliantly with a mixture of four ounces of beeswax, a quart of turpentine and a piece of rosin the size of a hickory nut. The beeswax must be cut, the rosin powdered and the two melted together. The turpentine is then stirred in. The polish is applied with a piece of flannel, and the floor then rubbed with dry flannel.

If the wall paper is slightly dingy it can best be restored to freshness by rubbing it with slices of dry bread. If it is quite dirty, chloroform will remove the stains. Chloroform will perform the same kindly service for sofa pillows which are not washable. These, however, should be packed away during the summer, and only those which are amenable to soap and water treatment should be used during the hot weather. Linen and washable silks are the best fabrics for summer pillows.

Scars on furniture may be obliterated or almost so by the use of kerosene, flannel cloths and vigorous rubbing. Upholstered furniture should be brushed with a whisk broom, covered with loose cotton cloths, made the repository of camphor and put away in the garret. Only wicker, cane, wood or matting furniture should be allowed in well-regulated houses during dog days.

China bric-a-brac should be washed in tepid water with castile soap and then rinsed with clear water. Ammonia should not be used, because of its paint-removing qualities.

In the dining room the china closet and the sideboard should be cleared of their loads, shelf by shelf. The china and glass should be washed in hot water in which there is ammonia. Cut glass should be scoured with a coarse brush. Before the contents of the closet are returned to them the shelves should be scrubbed, dried and covered with thin white paper. In the corners borax should be sprinkled as a preventive of water bugs. The inside shelves of the sideboard should be similarly treated.

In the kitchen the summer season should be inaugurated not only by ~

scouring of pots and pans and a polishing of ranges and faucets, but by the examination and renovation of the plumbing, if it needs it. The ice chest must be cleaned thoroughly by scrubbing with soap and water, rinsing with hot water to which common soda has been added, final rinsing in clear water, thorough drying and as complete an exposure of all the compartments to the sun as possible.

When surprised by days of unusual warmth before beginning to take a daily supply of ice, there may be some difficulty in keeping the poultry fresh that has been purchased several days before it is used. On receiving the poultry remove the entrails; this should never be delayed a moment longer than is necessary. Then wipe out clean with a towel and flour the inside. A piece of blotting paper on which one or two drops of creosote have been placed is now placed inside the bird, and another piece, similarly scented, is wrapped around it. The bird must then be hung up in dry, cool place.

—New York World.

Polishing cloths such as jewelers use are warranted to keep silver in brilliant condition without the disadvantages of a periodical upheaval of the plate closet. They prevent, moreover, the scratching which the application of powders to the metal usually produces. To make them, boil soft rags in a mixture of fresh milk and hartshorn powder, an ounce of the powder being used to a pint of milk. When they have boiled for five minutes, they should be hastily passed through cold water, so that they will be cool enough to wring out and dried before the fire. After the silver is washed and dried each day, it should be polished with a cloth prepared in this manner.

* * *

Some epicureans declare that cheese should be barred from well-regulated tables during the months when the oyster enjoys its annual vacation. But while April lasts a salad

of lettuce and cream cheese is a delicious luncheon or supper dish. The cream cheese should be colored green with the juice of boiled spinach, then seasoned with pepper and made into balls about the size of a walnut. On a flat, wide dish the hearts of lettuce heads should be formed into nests holding three or four cheese balls each. The salad should be accompanied by mayonnaise dressing.

* * *

It is a waste of time and energy for the woman who does her own scullery work to try to scrape clean scorched and blackened baking dishes and platters. Even rubbing them with dampened salt is a tedious process. If a little ashes and water are placed in the dishes and they are then allowed to heat slowly on the back of the range, they may be easily rubbed into their original state of spotlessness.

BYGONE DAYS.

By Mrs. J. R. Clausen.

How friends oft drift asunder;
And those, who fondly met,
Will, as the years roll o'er us,
Seem often to forget.

A voice, so soft and tender;
The tone so sweet and low;
We thought sure must linger
With us, where'er we go.

That smile, so bright and sunny,
Once a sunbeam on our way;
How many thoughts it wakens,
Of a glad and happy day.

And words of wisdom spoken,
From heart, so fond and true;
That taught us how to lighten
With love the work we do.

Yes, they are parted from us,
And we seem oft to forget;
But in our hearts their memory
Will linger with us yet.